

AMENDED IN ASSEMBLY AUGUST 4, 2014

AMENDED IN ASSEMBLY JUNE 10, 2014

AMENDED IN SENATE MARCH 17, 2014

SENATE BILL

No. 959

Introduced by Senator Hernandez

February 6, 2014

An act to amend Section 100503 of the Government Code, to amend Sections *1357.500*, *1357.503*, *1366.6*, *1367.005*, *1367.006*, *1374.21*, *1385.03*, ~~*1385.06*~~, ~~*1385.07*~~, *1385.11*, *1389.25*, and *1399.849* of the Health and Safety Code, and to amend Sections *10112.27*, *10112.28*, *10112.3*, *10113.9*, *10181.3*, ~~*10181.6*~~, ~~*10181.7*~~, *10181.11*, *10199.1*, *10753.05*, and *10965.3* of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 959, as amended, Hernandez. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA requires a health insurance issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool. PPACA also requires an issuer to establish an index rate for each of those markets based on the total combined claim costs for providing essential health benefits within the single risk pool for that market and authorizes the

issuer to vary premium rates from the index rate based only on specified factors. PPACA requires that the index rate be adjusted based on Exchange user fees and expected payments and charges under certain risk adjustment and reinsurance programs.

Existing law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer to consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered small-~~employer~~ *group market* plans and to also consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered individual market plans. Existing law requires a plan or insurer to establish an index rate for those markets, as specified, and authorizes the plan or insurer to vary premium rates from the index rate based only on specified factors. Existing law requires that the index rate be adjusted based on expected payments and charges under the risk adjustment and reinsurance programs specified under PPACA.

This bill would require that the index rate also be adjusted based on Exchange user fees, as specified under PPACA.

PPACA requires a health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, provides the platinum, gold, silver, or bronze level of coverage or, in the individual market, provides catastrophic coverage to specified individuals. Existing law requires health care service plans and health insurers participating in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product in each of these 5 levels of coverage. Existing law requires a health care service plan or health insurer that does not participate in the Exchange to offer at least one standardized product designated by the Exchange in each of the platinum, gold, silver, and bronze levels of coverage.

This bill would *define the term “health benefit plan” for purposes of the provisions governing nongrandfathered small employer health care*

service plans. The bill would specify that health care service plans and health insurers participating in the small group market of the Exchange are only required to fairly and affirmatively offer, market, and sell in that market the platinum, gold, silver, and bronze levels of coverage. The bill would also specify that the requirement for plans or insurers not participating in the Exchange to offer at least one standardized product designated by the Exchange in each of those levels of coverage only applies to the individual and small group markets.

(2) Existing law prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice to the subscriber or policyholder at least 60 days prior to the contract or policy renewal date.

The bill would require that the notice be sent on the earlier of 60 days prior to the renewal date or 15 days prior to the start of the annual enrollment period applicable to the contract or policy.

Existing law requires a plan or insurer that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual or small group coverage at a rate that is higher than the standard rate to provide the applicant with the reason for the decision in writing. Existing law also requires the plan or insurer to inform the applicant about specified high risk pools, including the California Major Risk Medical Insurance Program, and specifies that this requirement does not apply when a plan or insurer rejects an applicant for Medicare supplement coverage.

This bill would delete the requirement that the plan or insurer provide the applicant with the reason for the denial or higher than standard rate. The bill would require a plan or insurer to inform specified applicants for a grandfathered health plan who are denied or charged a higher than standard rate, and applicants for Medicare supplement coverage who are denied due to a specified condition, about the California Major Risk Medical Insurance Program and the Exchange, as specified.

(3) Existing law requires a health care service plan or health insurer in the individual or small group market to file rate information with the Department of Managed Health Care or the Department of Insurance, as applicable, at least 60 days prior to implementing a rate change and requires the filing to be concurrent with the notice sent to subscribers prior to increasing premium rates. Existing law requires that the rate filing include specified information regarding the proposed rate increase and the plan's overall annual medical trend factor assumptions in each

rate filing for all benefits and by aggregate benefit category. Existing law authorizes the plan to provide aggregated additional data that demonstrates year-to-year cost increases in specific benefit categories in major geographic regions of the state to be defined by the ~~department~~ *departments* to include no more than 9 regions.

This bill would eliminate the requirement that the rate filing be concurrent with the notice sent to subscribers prior to increasing premium rates. The bill would also ~~require that a rate filing include specified information regarding a plan or insurer's proposed rate change, rather than rate increase, and would require that the geographic regions correspond with those regions used by the plan to establish premium rates.~~

~~The bill would make other related, conforming, and technical changes.~~

(4) This bill would incorporate additional changes to Section 10753.05 of the Insurance Code proposed by SB 1034 that would become operative if this bill and SB 1034 are both enacted and this bill is enacted last.

~~(4)~~

(5) Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 100503 of the Government Code, as
2 amended by Section 4 of Chapter 5 of the First Extraordinary
3 Session of the Statutes of 2013, is amended to read:

4 100503. In addition to meeting the minimum requirements of
5 Section 1311 of the federal act, the board shall do all of the
6 following:

7 (a) Determine the criteria and process for eligibility, enrollment,
8 and disenrollment of enrollees and potential enrollees in the
9 Exchange and coordinate that process with the state and local

1 government entities administering other health care coverage
2 programs, including the State Department of Health Care Services,
3 the Managed Risk Medical Insurance Board, and California
4 counties, in order to ensure consistent eligibility and enrollment
5 processes and seamless transitions between coverage.

6 (b) Develop processes to coordinate with the county entities
7 that administer eligibility for the Medi-Cal program and the entity
8 that determines eligibility for the Healthy Families Program,
9 including, but not limited to, processes for case transfer, referral,
10 and enrollment in the Exchange of individuals applying for
11 assistance to those entities, if allowed or required by federal law.

12 (c) Determine the minimum requirements a carrier must meet
13 to be considered for participation in the Exchange, and the
14 standards and criteria for selecting qualified health plans to be
15 offered through the Exchange that are in the best interests of
16 qualified individuals and qualified small employers. The board
17 shall consistently and uniformly apply these requirements,
18 standards, and criteria to all carriers. In the course of selectively
19 contracting for health care coverage offered to qualified individuals
20 and qualified small employers through the Exchange, the board
21 shall seek to contract with carriers so as to provide health care
22 coverage choices that offer the optimal combination of choice,
23 value, quality, and service.

24 (d) Provide, in each region of the state, a choice of qualified
25 health plans at each of the five levels of coverage contained in
26 subsections (d) and (e) of Section 1302 of the federal act, subject
27 to subdivision (e) of this section, paragraph (2) of subdivision (d)
28 of Section 1366.6 of the Health and Safety Code, and paragraph
29 (2) of subdivision (d) of Section 10112.3 of the Insurance Code.

30 (e) Require, as a condition of participation in the individual
31 market of the Exchange, carriers to fairly and affirmatively offer,
32 market, and sell in the individual market of the Exchange at least
33 one product within each of the five levels of coverage contained
34 in subsections (d) and (e) of Section 1302 of the federal act and
35 require, as a condition of participation in the SHOP Program,
36 carriers to fairly and affirmatively offer, market, and sell in the
37 SHOP Program at least one product within each of the four levels
38 of coverage contained in subsection (d) of Section 1302 of the
39 federal act. The board may require carriers to offer additional
40 products within each of those levels of coverage. This subdivision

1 shall not apply to a carrier that solely offers supplemental coverage
2 in the Exchange under paragraph (10) of subdivision (a) of Section
3 100504.

4 (f) (1) Except as otherwise provided in this section and Section
5 100504.5, require, as a condition of participation in the Exchange,
6 carriers that sell any products outside the Exchange to do both of
7 the following:

8 (A) Fairly and affirmatively offer, market, and sell all products
9 made available to individuals in the Exchange to individuals
10 purchasing coverage outside the Exchange.

11 (B) Fairly and affirmatively offer, market, and sell all products
12 made available to small employers in the Exchange to small
13 employers purchasing coverage outside the Exchange.

14 (2) For purposes of this subdivision, “product” does not include
15 contracts entered into pursuant to Part 6.2 (commencing with
16 Section 12693) of Division 2 of the Insurance Code between the
17 Managed Risk Medical Insurance Board and carriers for enrolled
18 Healthy Families beneficiaries or contracts entered into pursuant
19 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
20 (commencing with Section 14200) of, Part 3 of Division 9 of the
21 Welfare and Institutions Code between the State Department of
22 Health Care Services and carriers for enrolled Medi-Cal
23 beneficiaries. “Product” also does not include a bridge plan product
24 offered pursuant to Section 100504.5.

25 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal
26 act, a carrier offering a bridge plan product in the Exchange may
27 limit the products it offers in the Exchange solely to a bridge plan
28 product contract.

29 (g) Determine when an enrollee’s coverage commences and the
30 extent and scope of coverage.

31 (h) Provide for the processing of applications and the enrollment
32 and disenrollment of enrollees.

33 (i) Determine and approve cost-sharing provisions for qualified
34 health plans.

35 (j) Establish uniform billing and payment policies for qualified
36 health plans offered in the Exchange to ensure consistent
37 enrollment and disenrollment activities for individuals enrolled in
38 the Exchange.

39 (k) Undertake activities necessary to market and publicize the
40 availability of health care coverage and federal subsidies through

the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(l) Select and set performance standards and compensation for navigators selected under subdivision (l) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

(B) The salaries established by the board under subparagraph (A) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (A).

(C) The Department of Human Resources shall review the methodology used in the surveys conducted pursuant to subparagraph (A).

(3) The positions described in paragraph (1) and subdivision (i) of Section 100500 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the

1 development, operations, and prudent cash management of the
2 Exchange. This charge shall not affect the requirement under
3 Section 1301 of the federal act that carriers charge the same
4 premium rate for each qualified health plan whether offered inside
5 or outside the Exchange.

6 (o) Authorize expenditures, as necessary, from the California
7 Health Trust Fund to pay program expenses to administer the
8 Exchange.

9 (p) Keep an accurate accounting of all activities, receipts, and
10 expenditures, and annually submit to the United States Secretary
11 of Health and Human Services a report concerning that accounting.
12 Commencing January 1, 2016, the board shall conduct an annual
13 audit.

14 (q) (1) Annually prepare a written report on the implementation
15 and performance of the Exchange functions during the preceding
16 fiscal year, including, at a minimum, the manner in which funds
17 were expended and the progress toward, and the achievement of,
18 the requirements of this title. The report shall also include data
19 provided by health care service plans and health insurers offering
20 bridge plan products regarding the extent of health care provider
21 and health facility overlap in their Medi-Cal networks as compared
22 to the health care provider and health facility networks contracting
23 with the plan or insurer in their bridge plan contracts. This report
24 shall be transmitted to the Legislature and the Governor and shall
25 be made available to the public on the Internet Web site of the
26 Exchange. A report made to the Legislature pursuant to this
27 subdivision shall be submitted pursuant to Section 9795.

28 (2) The Exchange shall prepare, or contract for the preparation
29 of, an evaluation of the bridge plan program using the first three
30 years of experience with the program. The evaluation shall be
31 provided to the health policy and fiscal committees of the
32 Legislature in the fourth year following federal approval of the
33 bridge plan option. The evaluation shall include, but not be limited
34 to, all of the following:

35 (A) The number of individuals eligible to participate in the
36 bridge plan program each year by category of eligibility.

37 (B) The number of eligible individuals who elect a bridge plan
38 option each year by category of eligibility.

1 (C) The average length of time, by region and statewide, that
2 individuals remain in the bridge plan option each year by category
3 of eligibility.

4 (D) The regions of the state with a bridge plan option, and the
5 carriers in each region that offer a bridge plan, by year.

6 (E) The premium difference each year, by region, between the
7 bridge plan and the first and second lowest cost plan for individuals
8 in the Exchange who are not eligible for the bridge plan.

9 (F) The effect of the bridge plan on the premium subsidy amount
10 for bridge plan eligible individuals each year by each region.

11 (G) Based on a survey of individuals enrolled in the bridge plan:

12 (i) Whether individuals enrolling in the bridge plan product are
13 able to keep their existing health care providers.

14 (ii) Whether individuals would want to retain their bridge plan
15 product, buy a different Exchange product, or decline to purchase
16 health insurance if there was no bridge plan product available. The
17 Exchange may include questions designed to elicit the information
18 in this subparagraph as part of an existing survey of individuals
19 receiving coverage in the Exchange.

20 (3) In addition to the evaluation required by paragraph (2), the
21 Exchange shall post the items in subparagraphs (A) to (F),
22 inclusive, on its Internet Web site each year.

23 (4) In addition to the report described in paragraph (1), the board
24 shall be responsive to requests for additional information from the
25 Legislature, including providing testimony and commenting on
26 proposed state legislation or policy issues. The Legislature finds
27 and declares that activities including, but not limited to, responding
28 to legislative or executive inquiries, tracking and commenting on
29 legislation and regulatory activities, and preparing reports on the
30 implementation of this title and the performance of the Exchange,
31 are necessary state requirements and are distinct from the
32 promotion of legislative or regulatory modifications referred to in
33 subdivision (d) of Section 100520.

34 (r) Maintain enrollment and expenditures to ensure that
35 expenditures do not exceed the amount of revenue in the fund, and
36 if sufficient revenue is not available to pay estimated expenditures,
37 institute appropriate measures to ensure fiscal solvency.

38 (s) Exercise all powers reasonably necessary to carry out and
39 comply with the duties, responsibilities, and requirements of this
40 act and the federal act.

1 (t) Consult with stakeholders relevant to carrying out the
2 activities under this title, including, but not limited to, all of the
3 following:

4 (1) Health care consumers who are enrolled in health plans.

5 (2) Individuals and entities with experience in facilitating
6 enrollment in health plans.

7 (3) Representatives of small businesses and self-employed
8 individuals.

9 (4) The State Medi-Cal Director.

10 (5) Advocates for enrolling hard-to-reach populations.

11 (u) Facilitate the purchase of qualified health plans in the
12 Exchange by qualified individuals and qualified small employers
13 no later than January 1, 2014.

14 (v) Report, or contract with an independent entity to report, to
15 the Legislature by December 1, 2018, on whether to adopt the
16 option in Section 1312(c)(3) of the federal act to merge the
17 individual and small employer markets. In its report, the board
18 shall provide information, based on at least two years of data from
19 the Exchange, on the potential impact on rates paid by individuals
20 and by small employers in a merged individual and small employer
21 market, as compared to the rates paid by individuals and small
22 employers if a separate individual and small employer market is
23 maintained. A report made pursuant to this subdivision shall be
24 submitted pursuant to Section 9795.

25 (w) With respect to the SHOP Program, collect premiums and
26 administer all other necessary and related tasks, including, but not
27 limited to, enrollment and plan payment, in order to make the
28 offering of employee plan choice as simple as possible for qualified
29 small employers.

30 (x) Require carriers participating in the Exchange to immediately
31 notify the Exchange, under the terms and conditions established
32 by the board when an individual is or will be enrolled in or
33 disenrolled from any qualified health plan offered by the carrier.

34 (y) Ensure that the Exchange provides oral interpretation
35 services in any language for individuals seeking coverage through
36 the Exchange and makes available a toll-free telephone number
37 for the hearing and speech impaired. The board shall ensure that
38 written information made available by the Exchange is presented
39 in a plainly worded, easily understandable format and made
40 available in prevalent languages.

1 (z) This section shall become inoperative on the October 1 that
2 is five years after the date that federal approval of the bridge plan
3 option occurs, and, as of the second January 1 thereafter, is
4 repealed, unless a later enacted statute that is enacted before that
5 date deletes or extends the dates on which it becomes inoperative
6 and is repealed.

7 SEC. 2. Section 100503 of the Government Code, as added by
8 Section 5 of Chapter 5 of the First Extraordinary Session of the
9 Statutes of 2013, is amended to read:

10 100503. In addition to meeting the minimum requirements of
11 Section 1311 of the federal act, the board shall do all of the
12 following:

13 (a) Determine the criteria and process for eligibility, enrollment,
14 and disenrollment of enrollees and potential enrollees in the
15 Exchange and coordinate that process with the state and local
16 government entities administering other health care coverage
17 programs, including the State Department of Health Care Services,
18 the Managed Risk Medical Insurance Board, and California
19 counties, in order to ensure consistent eligibility and enrollment
20 processes and seamless transitions between coverage.

21 (b) Develop processes to coordinate with the county entities
22 that administer eligibility for the Medi-Cal program and the entity
23 that determines eligibility for the Healthy Families Program,
24 including, but not limited to, processes for case transfer, referral,
25 and enrollment in the Exchange of individuals applying for
26 assistance to those entities, if allowed or required by federal law.

27 (c) Determine the minimum requirements a carrier must meet
28 to be considered for participation in the Exchange, and the
29 standards and criteria for selecting qualified health plans to be
30 offered through the Exchange that are in the best interests of
31 qualified individuals and qualified small employers. The board
32 shall consistently and uniformly apply these requirements,
33 standards, and criteria to all carriers. In the course of selectively
34 contracting for health care coverage offered to qualified individuals
35 and qualified small employers through the Exchange, the board
36 shall seek to contract with carriers so as to provide health care
37 coverage choices that offer the optimal combination of choice,
38 value, quality, and service.

39 (d) Provide, in each region of the state, a choice of qualified
40 health plans at each of the five levels of coverage contained in

1 subsections (d) and (e) of Section 1302 of the federal act, subject
2 to subdivision (e) of this section, paragraph (2) of subdivision (d)
3 of Section 1366.6 of the Health and Safety Code and paragraph
4 (2) of subdivision (d) of Section 10112.3 of the Insurance Code.

5 (e) Require, as a condition of participation in the Exchange,
6 carriers to fairly and affirmatively offer, market, and sell in the
7 Exchange at least one product within each of the five levels of
8 coverage contained in subsections (d) and (e) of Section 1302 of
9 the federal act and require, as a condition of participation in the
10 SHOP Program, carriers to fairly and affirmatively offer, market,
11 and sell in the SHOP Program at least one product within each of
12 the four levels of coverage contained in subsection (d) of Section
13 1302 of the federal act. The board may require carriers to offer
14 additional products within each of those levels of coverage. This
15 subdivision shall not apply to a carrier that solely offers
16 supplemental coverage in the Exchange under paragraph (10) of
17 subdivision (a) of Section 100504.

18 (f) (1) Require, as a condition of participation in the Exchange,
19 carriers that sell any products outside the Exchange to do both of
20 the following:

21 (A) Fairly and affirmatively offer, market, and sell all products
22 made available to individuals in the Exchange to individuals
23 purchasing coverage outside the Exchange.

24 (B) Fairly and affirmatively offer, market, and sell all products
25 made available to small employers in the Exchange to small
26 employers purchasing coverage outside the Exchange.

27 (2) For purposes of this subdivision, “product” does not include
28 contracts entered into pursuant to Part 6.2 (commencing with
29 Section 12693) of Division 2 of the Insurance Code between the
30 Managed Risk Medical Insurance Board and carriers for enrolled
31 Healthy Families beneficiaries or contracts entered into pursuant
32 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
33 (commencing with Section 14200) of, Part 3 of Division 9 of the
34 Welfare and Institutions Code between the State Department of
35 Health Care Services and carriers for enrolled Medi-Cal
36 beneficiaries.

37 (g) Determine when an enrollee’s coverage commences and the
38 extent and scope of coverage.

39 (h) Provide for the processing of applications and the enrollment
40 and disenrollment of enrollees.

1 (i) Determine and approve cost-sharing provisions for qualified
2 health plans.

3 (j) Establish uniform billing and payment policies for qualified
4 health plans offered in the Exchange to ensure consistent
5 enrollment and disenrollment activities for individuals enrolled in
6 the Exchange.

7 (k) Undertake activities necessary to market and publicize the
8 availability of health care coverage and federal subsidies through
9 the Exchange. The board shall also undertake outreach and
10 enrollment activities that seek to assist enrollees and potential
11 enrollees with enrolling and reenrolling in the Exchange in the
12 least burdensome manner, including populations that may
13 experience barriers to enrollment, such as the disabled and those
14 with limited English language proficiency.

15 (l) Select and set performance standards and compensation for
16 navigators selected under subdivision (l) of Section 100502.

17 (m) Employ necessary staff.

18 (1) The board shall hire a chief fiscal officer, a chief operations
19 officer, a director for the SHOP Exchange, a director of Health
20 Plan Contracting, a chief technology and information officer, a
21 general counsel, and other key executive positions, as determined
22 by the board, who shall be exempt from civil service.

23 (2) (A) The board shall set the salaries for the exempt positions
24 described in paragraph (1) and subdivision (i) of Section 100500
25 in amounts that are reasonably necessary to attract and retain
26 individuals of superior qualifications. The salaries shall be
27 published by the board in the board's annual budget. The board's
28 annual budget shall be posted on the Internet Web site of the
29 Exchange. To determine the compensation for these positions, the
30 board shall cause to be conducted, through the use of independent
31 outside advisors, salary surveys of both of the following:

32 (i) Other state and federal health insurance exchanges that are
33 most comparable to the Exchange.

34 (ii) Other relevant labor pools.

35 (B) The salaries established by the board under subparagraph
36 (A) shall not exceed the highest comparable salary for a position
37 of that type, as determined by the surveys conducted pursuant to
38 subparagraph (A).

1 (C) The Department of Human Resources shall review the
2 methodology used in the surveys conducted pursuant to
3 subparagraph (A).

4 (3) The positions described in paragraph (1) and subdivision (i)
5 of Section 100500 shall not be subject to otherwise applicable
6 provisions of the Government Code or the Public Contract Code
7 and, for those purposes, the Exchange shall not be considered a
8 state agency or public entity.

9 (n) Assess a charge on the qualified health plans offered by
10 carriers that is reasonable and necessary to support the
11 development, operations, and prudent cash management of the
12 Exchange. This charge shall not affect the requirement under
13 Section 1301 of the federal act that carriers charge the same
14 premium rate for each qualified health plan whether offered inside
15 or outside the Exchange.

16 (o) Authorize expenditures, as necessary, from the California
17 Health Trust Fund to pay program expenses to administer the
18 Exchange.

19 (p) Keep an accurate accounting of all activities, receipts, and
20 expenditures, and annually submit to the United States Secretary
21 of Health and Human Services a report concerning that accounting.
22 Commencing January 1, 2016, the board shall conduct an annual
23 audit.

24 (q) (1) Annually prepare a written report on the implementation
25 and performance of the Exchange functions during the preceding
26 fiscal year, including, at a minimum, the manner in which funds
27 were expended and the progress toward, and the achievement of,
28 the requirements of this title. This report shall be transmitted to
29 the Legislature and the Governor and shall be made available to
30 the public on the Internet Web site of the Exchange. A report made
31 to the Legislature pursuant to this subdivision shall be submitted
32 pursuant to Section 9795.

33 (2) In addition to the report described in paragraph (1), the board
34 shall be responsive to requests for additional information from the
35 Legislature, including providing testimony and commenting on
36 proposed state legislation or policy issues. The Legislature finds
37 and declares that activities including, but not limited to, responding
38 to legislative or executive inquiries, tracking and commenting on
39 legislation and regulatory activities, and preparing reports on the
40 implementation of this title and the performance of the Exchange,

1 are necessary state requirements and are distinct from the
2 promotion of legislative or regulatory modifications referred to in
3 subdivision (d) of Section 100520.

4 (r) Maintain enrollment and expenditures to ensure that
5 expenditures do not exceed the amount of revenue in the fund, and
6 if sufficient revenue is not available to pay estimated expenditures,
7 institute appropriate measures to ensure fiscal solvency.

8 (s) Exercise all powers reasonably necessary to carry out and
9 comply with the duties, responsibilities, and requirements of this
10 act and the federal act.

11 (t) Consult with stakeholders relevant to carrying out the
12 activities under this title, including, but not limited to, all of the
13 following:

14 (1) Health care consumers who are enrolled in health plans.

15 (2) Individuals and entities with experience in facilitating
16 enrollment in health plans.

17 (3) Representatives of small businesses and self-employed
18 individuals.

19 (4) The State Medi-Cal Director.

20 (5) Advocates for enrolling hard-to-reach populations.

21 (u) Facilitate the purchase of qualified health plans in the
22 Exchange by qualified individuals and qualified small employers
23 no later than January 1, 2014.

24 (v) Report, or contract with an independent entity to report, to
25 the Legislature by December 1, 2018, on whether to adopt the
26 option in Section 1312(c)(3) of the federal act to merge the
27 individual and small employer markets. In its report, the board
28 shall provide information, based on at least two years of data from
29 the Exchange, on the potential impact on rates paid by individuals
30 and by small employers in a merged individual and small employer
31 market, as compared to the rates paid by individuals and small
32 employers if a separate individual and small employer market is
33 maintained. A report made pursuant to this subdivision shall be
34 submitted pursuant to Section 9795.

35 (w) With respect to the SHOP Program, collect premiums and
36 administer all other necessary and related tasks, including, but not
37 limited to, enrollment and plan payment, in order to make the
38 offering of employee plan choice as simple as possible for qualified
39 small employers.

(x) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the board when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

(y) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(z) This section shall become operative only if Section 4 of the act that added this section becomes inoperative pursuant to subdivision (z) of that Section 4.

SEC. 3. Section 1357.500 of the Health and Safety Code is amended to read:

1357.500. As used in this article, the following definitions shall apply:

(a) “Child” means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(b) “Dependent” means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (m).

(c) “Eligible employee” means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer’s regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in

1 this paragraph, who obtains coverage through a guaranteed
2 association. Employees of employers purchasing through a
3 guaranteed association shall be deemed to be eligible employees
4 if they would otherwise meet the definition except for the number
5 of persons employed by the employer. Permanent employees who
6 work at least 20 hours but not more than 29 hours are deemed to
7 be eligible employees if all four of the following apply:

8 (A) They otherwise meet the definition of an eligible employee
9 except for the number of hours worked.

10 (B) The employer offers the employees health coverage under
11 a health benefit plan.

12 (C) All similarly situated individuals are offered coverage under
13 the health benefit plan.

14 (D) The employee must have worked at least 20 hours per
15 normal workweek for at least 50 percent of the weeks in the
16 previous calendar quarter. The health care service plan may request
17 any necessary information to document the hours and time period
18 in question, including, but not limited to, payroll records and
19 employee wage and tax filings.

20 (2) Any member of a guaranteed association as defined in
21 subdivision (m).

22 (d) "Exchange" means the California Health Benefit Exchange
23 created by Section 100500 of the Government Code.

24 (e) "In force business" means an existing health benefit plan
25 contract issued by the plan to a small employer.

26 (f) "Late enrollee" means an eligible employee or dependent
27 who has declined enrollment in a health benefit plan offered by a
28 small employer at the time of the initial enrollment period provided
29 under the terms of the health benefit plan consistent with the
30 periods provided pursuant to Section 1357.503 and who
31 subsequently requests enrollment in a health benefit plan of that
32 small employer, except where the employee or dependent qualifies
33 for a special enrollment period provided pursuant to Section
34 1357.503. It also means any member of an association that is a
35 guaranteed association as well as any other person eligible to
36 purchase through the guaranteed association when that person has
37 failed to purchase coverage during the initial enrollment period
38 provided under the terms of the guaranteed association's plan
39 contract consistent with the periods provided pursuant to Section
40 1357.503 and who subsequently requests enrollment in the plan,

1 except where that member or person qualifies for a special
2 enrollment period provided pursuant to Section 1357.503.

3 (g) “New business” means a health care service plan contract
4 issued to a small employer that is not the plan’s in force business.

5 (h) “Preexisting condition provision” means a contract provision
6 that excludes coverage for charges or expenses incurred during a
7 specified period following the enrollee’s effective date of coverage,
8 as to a condition for which medical advice, diagnosis, care, or
9 treatment was recommended or received during a specified period
10 immediately preceding the effective date of coverage. No health
11 care service plan shall limit or exclude coverage for any individual
12 based on a preexisting condition whether or not any medical advice,
13 diagnosis, care, or treatment was recommended or received before
14 that date.

15 (i) “Creditable coverage” means:

16 (1) Any individual or group policy, contract, or program that is
17 written or administered by a disability insurer, health care service
18 plan, fraternal benefits society, self-insured employer plan, or any
19 other entity, in this state or elsewhere, and that arranges or provides
20 medical, hospital, and surgical coverage not designed to supplement
21 other private or governmental plans. The term includes continuation
22 or conversion coverage but does not include accident only, credit,
23 coverage for onsite medical clinics, disability income, Medicare
24 supplement, long-term care, dental, vision, coverage issued as a
25 supplement to liability insurance, insurance arising out of a
26 workers’ compensation or similar law, automobile medical payment
27 insurance, or insurance under which benefits are payable with or
28 without regard to fault and that is statutorily required to be
29 contained in any liability insurance policy or equivalent
30 self-insurance.

31 (2) The Medicare program pursuant to Title XVIII of the federal
32 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

33 (3) The Medicaid Program pursuant to Title XIX of the federal
34 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

35 (4) Any other publicly sponsored program, provided in this state
36 or elsewhere, of medical, hospital, and surgical care.

37 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
38 (Civilian Health and Medical Program of the Uniformed Services
39 (CHAMPUS)).

1 (6) A medical care program of the Indian Health Service or of
2 a tribal organization.

3 (7) A health plan offered under 5 U.S.C. Chapter 89
4 (commencing with Section 8901) (Federal Employees Health
5 Benefits Program (FEHBP)).

6 (8) A public health plan as defined in federal regulations
7 authorized by Section 2701(c)(1)(I) of the Public Health Service
8 Act, as amended by Public Law 104-191, the Health Insurance
9 Portability and Accountability Act of 1996.

10 (9) A health benefit plan under Section 5(e) of the Peace Corps
11 Act (22 U.S.C. Sec. 2504(e)).

12 (10) Any other creditable coverage as defined by subsection (c)
13 of Section 2704 of Title XXVII of the federal Public Health Service
14 Act (42 U.S.C. Sec. 300gg-3(c)).

15 (j) “Rating period” means the period for which premium rates
16 established by a plan are in effect and shall be no less than 12
17 months from the date of issuance or renewal of the plan contract.

18 (k) (1) “Small employer” means any of the following:

19 (A) For plan years commencing on or after January 1, 2014,
20 and on or before December 31, 2015, any person, firm, proprietary
21 or nonprofit corporation, partnership, public agency, or association
22 that is actively engaged in business or service, that, on at least 50
23 percent of its working days during the preceding calendar quarter
24 or preceding calendar year, employed at least one, but no more
25 than 50, eligible employees, the majority of whom were employed
26 within this state, that was not formed primarily for purposes of
27 buying health care service plan contracts, and in which a bona fide
28 employer-employee relationship exists. For plan years commencing
29 on or after January 1, 2016, any person, firm, proprietary or
30 nonprofit corporation, partnership, public agency, or association
31 that is actively engaged in business or service, that, on at least 50
32 percent of its working days during the preceding calendar quarter
33 or preceding calendar year, employed at least one, but no more
34 than 100, eligible employees, the majority of whom were employed
35 within this state, that was not formed primarily for purposes of
36 buying health care service plan contracts, and in which a bona fide
37 employer-employee relationship exists. In determining whether
38 to apply the calendar quarter or calendar year test, a health care
39 service plan shall use the test that ensures eligibility if only one
40 test would establish eligibility. In determining the number of

1 eligible employees, companies that are affiliated companies and
2 that are eligible to file a combined tax return for purposes of state
3 taxation shall be considered one employer. Subsequent to the
4 issuance of a health care service plan contract to a small employer
5 pursuant to this article, and for the purpose of determining
6 eligibility, the size of a small employer shall be determined
7 annually. Except as otherwise specifically provided in this article,
8 provisions of this article that apply to a small employer shall
9 continue to apply until the plan contract anniversary following the
10 date the employer no longer meets the requirements of this
11 definition. It includes any small employer as defined in this
12 paragraph who purchases coverage through a guaranteed
13 association, and any employer purchasing coverage for employees
14 through a guaranteed association. This subparagraph shall be
15 implemented to the extent consistent with PPACA, except that the
16 minimum requirement of one employee shall be implemented only
17 to the extent required by PPACA.

18 (B) Any guaranteed association, as defined in subdivision (l),
19 that purchases health coverage for members of the association.

20 (2) For plan years commencing on or after January 1, 2014, the
21 definition of an employer, for purposes of determining whether
22 an employer with one employee shall include sole proprietors,
23 certain owners of “S” corporations, or other individuals, shall be
24 consistent with Section 1304 of PPACA.

25 (l) “Guaranteed association” means a nonprofit organization
26 comprised of a group of individuals or employers who associate
27 based solely on participation in a specified profession or industry,
28 accepting for membership any individual or employer meeting its
29 membership criteria, and that (1) includes one or more small
30 employers as defined in subparagraph (A) of paragraph (1) of
31 subdivision (k), (2) does not condition membership directly or
32 indirectly on the health or claims history of any person, (3) uses
33 membership dues solely for and in consideration of the membership
34 and membership benefits, except that the amount of the dues shall
35 not depend on whether the member applies for or purchases
36 insurance offered to the association, (4) is organized and
37 maintained in good faith for purposes unrelated to insurance, (5)
38 has been in active existence on January 1, 1992, and for at least
39 five years prior to that date, (6) has included health insurance as
40 a membership benefit for at least five years prior to January 1,

1 1992, (7) has a constitution and bylaws, or other analogous
2 governing documents that provide for election of the governing
3 board of the association by its members, (8) offers any plan contract
4 that is purchased to all individual members and employer members
5 in this state, (9) includes any member choosing to enroll in the
6 plan contracts offered to the association provided that the member
7 has agreed to make the required premium payments, and (10)
8 covers at least 1,000 persons with the health care service plan with
9 which it contracts. The requirement of 1,000 persons may be met
10 if component chapters of a statewide association contracting
11 separately with the same carrier cover at least 1,000 persons in the
12 aggregate.

13 This subdivision applies regardless of whether a contract issued
14 by a plan is with an association, or a trust formed for or sponsored
15 by an association, to administer benefits for association members.

16 For purposes of this subdivision, an association formed by a
17 merger of two or more associations after January 1, 1992, and
18 otherwise meeting the criteria of this subdivision shall be deemed
19 to have been in active existence on January 1, 1992, if its
20 predecessor organizations had been in active existence on January
21 1, 1992, and for at least five years prior to that date and otherwise
22 met the criteria of this subdivision.

23 (m) “Members of a guaranteed association” means any
24 individual or employer meeting the association’s membership
25 criteria if that person is a member of the association and chooses
26 to purchase health coverage through the association. At the
27 association’s discretion, it also may include employees of
28 association members, association staff, retired members, retired
29 employees of members, and surviving spouses and dependents of
30 deceased members. However, if an association chooses to include
31 these persons as members of the guaranteed association, the
32 association shall make that election in advance of purchasing a
33 plan contract. Health care service plans may require an association
34 to adhere to the membership composition it selects for up to 12
35 months.

36 (n) “Affiliation period” means a period that, under the terms of
37 the health care service plan contract, must expire before health
38 care services under the contract become effective.

39 (o) “Grandfathered health plan” has the meaning set forth in
40 Section 1251 of PPACA.

(p) “Nongrandfathered small employer health care service plan contract” means a small employer health care service plan contract that is not a grandfathered health plan.

(q) “Plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(r) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(s) “Small employer health care service plan contract” means a health care service plan contract issued to a small employer.

(t) “Waiting period” means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

(u) “Registered domestic partner” means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) “Family” means the subscriber and his or her dependent or dependents.

(w) *“Health benefit plan” means a health care service plan contract that provides medical, hospital, and surgical benefits for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.*

~~SEC. 3.~~

SEC. 4. Section 1357.503 of the Health and Safety Code is amended to read:

1357.503. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan’s small employer health care service plan contracts for plan years on or after January 1, 2014, to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) On and after October 1, 2013, a plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state for plan

1 years on or after January 1, 2014. Health coverage through an
2 association that is not related to employment shall be considered
3 individual coverage pursuant to Section 144.102(c) of Title 45 of
4 the Code of Federal Regulations.

5 (3) A plan that offers qualified health plans through the
6 Exchange shall be deemed to be in compliance with paragraphs
7 (1) and (2) with respect to small employer health care service plan
8 contracts offered through the Exchange in those geographic regions
9 in which the plan offers plan contracts through the Exchange.

10 (b) A plan shall provide enrollment periods consistent with
11 PPACA and described in Section 155.725 of Title 45 of the Code
12 of Federal Regulations. Commencing January 1, 2014, a plan shall
13 provide special enrollment periods consistent with the special
14 enrollment periods described in Section 1399.849, to the extent
15 permitted by PPACA, except for the triggering events identified
16 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
17 the Code of Federal Regulations with respect to plan contracts
18 offered through the Exchange.

19 (c) No plan or solicitor shall induce or otherwise encourage a
20 small employer to separate or otherwise exclude an eligible
21 employee from a health care service plan contract that is provided
22 in connection with employee's employment or membership in a
23 guaranteed association.

24 (d) Every plan shall file with the director the reasonable
25 employee participation requirements and employer contribution
26 requirements that will be applied in offering its plan contracts.
27 Participation requirements shall be applied uniformly among all
28 small employer groups, except that a plan may vary application
29 of minimum employee participation requirements by the size of
30 the small employer group and whether the employer contributes
31 100 percent of the eligible employee's premium. Employer
32 contribution requirements shall not vary by employer size. A health
33 care service plan shall not establish a participation requirement
34 that (1) requires a person who meets the definition of a dependent
35 in Section 1357.500 to enroll as a dependent if he or she is
36 otherwise eligible for coverage and wishes to enroll as an eligible
37 employee and (2) allows a plan to reject an otherwise eligible small
38 employer because of the number of persons that waive coverage
39 due to coverage through another employer. Members of an
40 association eligible for health coverage under subdivision (m) of

1 Section 1357.500, but not electing any health coverage through
2 the association, shall not be counted as eligible employees for
3 purposes of determining whether the guaranteed association meets
4 a plan's reasonable participation standards.

5 (e) The plan shall not reject an application from a small
6 employer for a small employer health care service plan contract
7 if all of the following conditions are met:

8 (1) The small employer offers health benefits to 100 percent of
9 its eligible employees. Employees who waive coverage on the
10 grounds that they have other group coverage shall not be counted
11 as eligible employees.

12 (2) The small employer agrees to make the required premium
13 payments.

14 (3) The small employer agrees to inform the small employer's
15 employees of the availability of coverage and the provision that
16 those not electing coverage must wait until the next open
17 enrollment or a special enrollment period to obtain coverage
18 through the group if they later decide they would like to have
19 coverage.

20 (4) The employees and their dependents who are to be covered
21 by the plan contract work or reside in the service area in which
22 the plan provides or otherwise arranges for the provision of health
23 care services.

24 (f) No plan or solicitor shall, directly or indirectly, engage in
25 the following activities:

26 (1) Encourage or direct small employers to refrain from filing
27 an application for coverage with a plan because of the health status,
28 claims experience, industry, occupation of the small employer, or
29 geographic location provided that it is within the plan's approved
30 service area.

31 (2) Encourage or direct small employers to seek coverage from
32 another plan because of the health status, claims experience,
33 industry, occupation of the small employer, or geographic location
34 provided that it is within the plan's approved service area.

35 (3) Employ marketing practices or benefit designs that will have
36 the effect of discouraging the enrollment of individuals with
37 significant health needs or discriminate based on an individual's
38 race, color, national origin, present or predicted disability, age,
39 sex, gender identity, sexual orientation, expected length of life,

1 degree of medical dependency, quality of life, or other health
2 conditions.

3 (g) A plan shall not, directly or indirectly, enter into any
4 contract, agreement, or arrangement with a solicitor that provides
5 for or results in the compensation paid to a solicitor for the sale of
6 a health care service plan contract to be varied because of the health
7 status, claims experience, industry, occupation, or geographic
8 location of the small employer. This subdivision does not apply
9 to a compensation arrangement that provides compensation to a
10 solicitor on the basis of percentage of premium, provided that the
11 percentage shall not vary because of the health status, claims
12 experience, industry, occupation, or geographic area of the small
13 employer.

14 (h) (1) A policy or contract that covers a small employer, as
15 defined in Section 1304(b) of PPACA and in Section 1357.500,
16 shall not establish rules for eligibility, including continued
17 eligibility, of an individual, or dependent of an individual, to enroll
18 under the terms of the policy or contract based on any of the
19 following health status-related factors:

- 20 (A) Health status.
- 21 (B) Medical condition, including physical and mental illnesses.
- 22 (C) Claims experience.
- 23 (D) Receipt of health care.
- 24 (E) Medical history.
- 25 (F) Genetic information.
- 26 (G) Evidence of insurability, including conditions arising out
27 of acts of domestic violence.
- 28 (H) Disability.
- 29 (I) Any other health status-related factor as determined by any
30 federal regulations, rules, or guidance issued pursuant to Section
31 2705 of the federal Public Health Service Act.

32 (2) Notwithstanding Section 1389.1, a health care service plan
33 shall not require an eligible employee or dependent to fill out a
34 health assessment or medical questionnaire prior to enrollment
35 under a small employer health care service plan contract. A health
36 care service plan shall not acquire or request information that
37 relates to a health status-related factor from the applicant or his or
38 her dependent or any other source prior to enrollment of the
39 individual.

(i) (1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the health care service plan outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a health care service plan shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the nongrandfathered small employer ~~health care service plan contracts and nongrandfathered~~ health benefit plans within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the plan contract.

(B) The plan contract's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the plan contract that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plan contracts that offer those benefits in addition to essential health benefits.

1 (D) With respect to catastrophic plans, as described in subsection
2 (e) of Section 1302 of PPACA, the expected impact of the specific
3 eligibility categories for those plans.

4 (E) Administrative costs, excluding any user fees required by
5 the Exchange.

6 (j) A plan shall comply with the requirements of Section 1374.3.

7 (k) (1) Except as provided in paragraph (2), if Section 2702 of
8 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),
9 as added by Section 1201 of PPACA, is repealed, this section shall
10 become inoperative 12 months after the repeal date, in which case
11 health care service plans subject to this section shall instead be
12 governed by Section 1357.03 to the extent permitted by federal
13 law, and all references in this article to this section shall instead
14 refer to Section 1357.03 except for purposes of paragraph (2).

15 (2) Subdivision (b) shall remain operative with respect to health
16 care service plan contracts offered through the Exchange.

17 ~~SEC. 4.~~

18 *SEC. 5.* Section 1366.6 of the Health and Safety Code, as
19 amended by Section 8 of Chapter 5 of the First Extraordinary
20 Session of the Statutes of 2013, is amended to read:

21 1366.6. (a) For purposes of this section, the following
22 definitions shall apply:

23 (1) “Exchange” means the California Health Benefit Exchange
24 established in Title 22 (commencing with Section 100500) of the
25 Government Code.

26 (2) “Federal act” means the federal Patient Protection and
27 Affordable Care Act (Public Law 111-148), as amended by the
28 federal Health Care and Education Reconciliation Act of 2010
29 (Public Law 111-152), and any amendments to, or regulations or
30 guidance issued under, those acts.

31 (3) “Qualified health plan” has the same meaning as that term
32 is defined in Section 1301 of the federal act.

33 (4) “Small employer” has the same meaning as that term is
34 defined in Section 1357.500.

35 (b) (1) Health care service plans participating in the individual
36 market of the Exchange shall fairly and affirmatively offer, market,
37 and sell in the individual market of the Exchange at least one
38 product within each of the five levels of coverage contained in
39 subsections (d) and (e) of Section 1302 of the federal act. Health
40 care service plans participating in the Small Business Health

Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require plans to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(4) This subdivision shall not apply to a bridge plan product that meets the requirements of Section 100504.5 of the Government Code to the extent approved by the appropriate federal agency.

(c) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and health care service plans for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health care service plans for enrolled Medi-Cal beneficiaries, or for contracts with bridge plan products that meet the requirements of Section 100504.5 of the Government Code.

(d) (1) Commencing January 1, 2014, a health care service plan shall, with respect to individual plan contracts that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal

1 act, except that a health care service plan that does not participate
2 in the Exchange shall, with respect to individual plan contracts
3 that cover hospital, medical, or surgical benefits, only sell the four
4 levels of coverage contained in subsection (d) of Section 1302 of
5 the federal act.

6 (2) Commencing January 1, 2014, a health care service plan
7 shall, with respect to small employer plan contracts that cover
8 hospital, medical, or surgical expenses, only sell the four levels of
9 coverage contained in subsection (d) of Section 1302 of the federal
10 act.

11 (e) Commencing January 1, 2014, a health care service plan
12 that does not participate in the Exchange shall, with respect to
13 individual or small employer plan contracts that cover hospital,
14 medical, or surgical benefits, offer at least one standardized product
15 that has been designated by the Exchange in each of the four levels
16 of coverage contained in subsection (d) of Section 1302 of the
17 federal act. This subdivision shall only apply if the board of the
18 Exchange exercises its authority under subdivision (c) of Section
19 100504 of the Government Code. Nothing in this subdivision shall
20 require a plan that does not participate in the Exchange to offer
21 standardized products in the small employer market if the plan
22 only sells products in the individual market. Nothing in this
23 subdivision shall require a plan that does not participate in the
24 Exchange to offer standardized products in the individual market
25 if the plan only sells products in the small employer market. This
26 subdivision shall not be construed to prohibit the plan from offering
27 other products provided that it complies with subdivision (d).

28 (f) For purposes of this section, a bridge plan product shall mean
29 an individual health benefit plan, as defined in subdivision (f) of
30 Section 1399.845, that is offered by a health care service plan
31 licensed under this chapter that contracts with the Exchange
32 pursuant to Title 22 (commencing with Section 100500) of the
33 Government Code.

34 (g) This section shall become inoperative on the October 1 that
35 is five years after the date that federal approval of the bridge plan
36 option occurs, and, as of the second January 1 thereafter, is
37 repealed, unless a later enacted statute that is enacted before that
38 date deletes or extends the dates on which it becomes inoperative
39 and is repealed.

1 ~~SEC. 5.~~

2 *SEC. 6.* Section 1366.6 of the Health and Safety Code, as added
3 by Section 9 of Chapter 5 of the First Extraordinary Session of the
4 Statutes of 2013, is amended to read:

5 1366.6. (a) For purposes of this section, the following
6 definitions shall apply:

7 (1) “Exchange” means the California Health Benefit Exchange
8 established in Title 22 (commencing with Section 100500) of the
9 Government Code.

10 (2) “Federal act” means the federal Patient Protection and
11 Affordable Care Act (Public Law 111-148), as amended by the
12 federal Health Care and Education Reconciliation Act of 2010
13 (Public Law 111-152), and any amendments to, or regulations or
14 guidance issued under, those acts.

15 (3) “Qualified health plan” has the same meaning as that term
16 is defined in Section 1301 of the federal act.

17 (4) “Small employer” has the same meaning as that term is
18 defined in Section 1357.500.

19 (b) (1) Health care service plans participating in the individual
20 market of the Exchange shall fairly and affirmatively offer, market,
21 and sell in the individual market of the Exchange at least one
22 product within each of the five levels of coverage contained in
23 subsections (d) and (e) of Section 1302 of the federal act. Health
24 care service plans participating in the Small Business Health
25 Options Program (SHOP Program) of the Exchange, established
26 pursuant to subdivision (m) of Section 100504 of the Government
27 Code, shall fairly and affirmatively offer, market, and sell in the
28 SHOP Program at least one product within each of the four levels
29 of coverage contained in subsection (d) of Section 1302 of the
30 federal act.

31 (2) The board established under Section 100500 of the
32 Government Code may require plans to sell additional products
33 within each of the levels of coverage identified in paragraph (1).

34 (3) This subdivision shall not apply to a plan that solely offers
35 supplemental coverage in the Exchange under paragraph (10) of
36 subdivision (a) of Section 100504 of the Government Code.

37 (c) (1) Health care service plans participating in the Exchange
38 that sell any products outside the Exchange shall do both of the
39 following:

1 (A) Fairly and affirmatively offer, market, and sell all products
2 made available to individuals in the Exchange to individuals
3 purchasing coverage outside the Exchange.

4 (B) Fairly and affirmatively offer, market, and sell all products
5 made available to small employers in the Exchange to small
6 employers purchasing coverage outside the Exchange.

7 (2) For purposes of this subdivision, “product” does not include
8 contracts entered into pursuant to Part 6.2 (commencing with
9 Section 12693) of Division 2 of the Insurance Code between the
10 Managed Risk Medical Insurance Board and health care service
11 plans for enrolled Healthy Families beneficiaries or to contracts
12 entered into pursuant to Chapter 7 (commencing with Section
13 14000) of, or Chapter 8 (commencing with Section 14200) of, Part
14 3 of Division 9 of the Welfare and Institutions Code between the
15 State Department of Health Care Services and health care service
16 plans for enrolled Medi-Cal beneficiaries.

17 (d) (1) Commencing January 1, 2014, a health care service plan
18 shall, with respect to individual plan contracts that cover hospital,
19 medical, or surgical benefits, only sell the five levels of coverage
20 contained in subsections (d) and (e) of Section 1302 of the federal
21 act, except that a health care service plan that does not participate
22 in the Exchange shall, with respect to individual plan contracts
23 that cover hospital, medical, or surgical benefits, only sell the four
24 levels of coverage contained in subsection (d) of Section 1302 of
25 the federal act.

26 (2) Commencing January 1, 2014, a health care service plan
27 shall, with respect to small employer plan contracts that cover
28 hospital, medical, or surgical expenses, only sell the four levels of
29 coverage contained in subsection (d) of Section 1302 of the federal
30 act.

31 (e) Commencing January 1, 2014, a health care service plan
32 that does not participate in the Exchange shall, with respect to
33 individual or small employer plan contracts that cover hospital,
34 medical, or surgical benefits, offer at least one standardized product
35 that has been designated by the Exchange in each of the four levels
36 of coverage contained in subdivision (d) of Section 1302 of the
37 federal act. This subdivision shall only apply if the board of the
38 Exchange exercises its authority under subdivision (c) of Section
39 100504 of the Government Code. Nothing in this subdivision shall
40 require a plan that does not participate in the Exchange to offer

1 standardized products in the small employer market if the plan
2 only sells products in the individual market. Nothing in this
3 subdivision shall require a plan that does not participate in the
4 Exchange to offer standardized products in the individual market
5 if the plan only sells products in the small employer market. This
6 subdivision shall not be construed to prohibit the plan from offering
7 other products provided that it complies with subdivision (d).

8 (f) This section shall become operative only if Section 8 of the
9 act that added this section becomes inoperative pursuant to
10 subdivision (g) of that Section 8.

11 ~~SEC. 6.~~

12 *SEC. 7.* Section 1367.005 of the Health and Safety Code is
13 amended to read:

14 1367.005. (a) An individual or small group health care service
15 plan contract issued, amended, or renewed on or after January 1,
16 2014, shall, at a minimum, include coverage for essential health
17 benefits pursuant to PPACA and as outlined in this section. For
18 purposes of this section, “essential health benefits” means all of
19 the following:

20 (1) Health benefits within the categories identified in Section
21 1302(b) of PPACA: ambulatory patient services, emergency
22 services, hospitalization, maternity and newborn care, mental health
23 and substance use disorder services, including behavioral health
24 treatment, prescription drugs, rehabilitative and habilitative services
25 and devices, laboratory services, preventive and wellness services
26 and chronic disease management, and pediatric services, including
27 oral and vision care.

28 (2) (A) The health benefits covered by the Kaiser Foundation
29 Health Plan Small Group HMO 30 plan (federal health product
30 identification number 40513CA035) as this plan was offered during
31 the first quarter of 2012, as follows, regardless of whether the
32 benefits are specifically referenced in the evidence of coverage or
33 plan contract for that plan:

34 (i) Medically necessary basic health care services, as defined
35 in subdivision (b) of Section 1345 and in Section 1300.67 of Title
36 28 of the California Code of Regulations.

37 (ii) The health benefits mandated to be covered by the plan
38 pursuant to statutes enacted before December 31, 2011, as
39 described in the following sections: Sections 1367.002, 1367.06,
40 and 1367.35 (preventive services for children); Section 1367.25

1 (prescription drug coverage for contraceptives); Section 1367.45
 2 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51
 3 (diabetes); Section 1367.54 (alpha feto protein testing); Section
 4 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for
 5 laryngectomy); Section 1367.62 (maternity hospital stay); Section
 6 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies);
 7 Section 1367.64 (prostate cancer); Section 1367.65
 8 (mammography); Section 1367.66 (cervical cancer); Section
 9 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);
 10 Section 1367.68 (surgical procedures for jaw bones); Section
 11 1367.71 (anesthesia for dental); Section 1367.9 (conditions
 12 attributable to diethylstilbestrol); Section 1368.2 (hospice care);
 13 Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency
 14 response ambulance or ambulance transport services); subdivision
 15 (b) of Section 1373 (sterilization operations or procedures); Section
 16 1373.4 (inpatient hospital and ambulatory maternity); Section
 17 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for
 18 HIV); Section 1374.72 (mental health parity); and Section 1374.73
 19 (autism/behavioral health treatment).

20 (iii) Any other benefits mandated to be covered by the plan
 21 pursuant to statutes enacted before December 31, 2011, as
 22 described in those statutes.

23 (iv) The health benefits covered by the plan that are not
 24 otherwise required to be covered under this chapter, to the extent
 25 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
 26 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
 27 California Code of Regulations.

28 (v) Any other health benefits covered by the plan that are not
 29 otherwise required to be covered under this chapter.

30 (B) Where there are any conflicts or omissions in the plan
 31 identified in subparagraph (A) as compared with the requirements
 32 for health benefits under this chapter that were enacted prior to
 33 December 31, 2011, the requirements of this chapter shall be
 34 controlling, except as otherwise specified in this section.

35 (C) Notwithstanding subparagraph (B) or any other provision
 36 of this section, the home health services benefits covered under
 37 the plan identified in subparagraph (A) shall be deemed to not be
 38 in conflict with this chapter.

39 (D) For purposes of this section, the Paul Wellstone and Pete
 40 Domenici Mental Health Parity and Addiction Equity Act of 2008

(Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children’s Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

1 (d) To the extent permitted under Section 1302 of PPACA and
2 any rules, regulations, or guidance issued pursuant to that section,
3 and to the extent that substitution would not create an obligation
4 for the state to defray costs for any individual, a plan may substitute
5 its prescription drug formulary for the formulary provided under
6 the plan identified in subdivision (a) as long as the coverage for
7 prescription drugs complies with the sections referenced in clauses
8 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision
9 (a) that apply to prescription drugs.

10 (e) No health care service plan, or its agent, solicitor, or
11 representative, shall issue, deliver, renew, offer, market, represent,
12 or sell any product, contract, or discount arrangement as compliant
13 with the essential health benefits requirement in federal law, unless
14 it meets all of the requirements of this section.

15 (f) This section shall apply regardless of whether the plan
16 contract is offered inside or outside the California Health Benefit
17 Exchange created by Section 100500 of the Government Code.

18 (g) Nothing in this section shall be construed to exempt a plan
19 or a plan contract from meeting other applicable requirements of
20 law.

21 (h) This section shall not be construed to prohibit a plan contract
22 from covering additional benefits, including, but not limited to,
23 spiritual care services that are tax deductible under Section 213 of
24 the Internal Revenue Code.

25 (i) Subdivision (a) shall not apply to any of the following:

26 (1) A specialized health care service plan contract.

27 (2) A Medicare supplement plan.

28 (3) A plan contract that qualifies as a grandfathered health plan
29 under Section 1251 of PPACA or any rules, regulations, or
30 guidance issued pursuant to that section.

31 (j) Nothing in this section shall be implemented in a manner
32 that conflicts with a requirement of PPACA.

33 (k) This section shall be implemented only to the extent essential
34 health benefits are required pursuant to PPACA.

35 (l) An essential health benefit is required to be provided under
36 this section only to the extent that federal law does not require the
37 state to defray the costs of the benefit.

38 (m) Nothing in this section shall obligate the state to incur costs
39 for the coverage of benefits that are not essential health benefits
40 as defined in this section.

1 (n) A plan is not required to cover, under this section, changes
2 to health benefits that are the result of statutes enacted on or after
3 December 31, 2011.

4 (o) (1) The department may adopt emergency regulations
5 implementing this section. The department may, on a one-time
6 basis, readopt any emergency regulation authorized by this section
7 that is the same as, or substantially equivalent to, an emergency
8 regulation previously adopted under this section.

9 (2) The initial adoption of emergency regulations implementing
10 this section and the readoption of emergency regulations authorized
11 by this subdivision shall be deemed an emergency and necessary
12 for the immediate preservation of the public peace, health, safety,
13 or general welfare. The initial emergency regulations and the
14 readoption of emergency regulations authorized by this section
15 shall be submitted to the Office of Administrative Law for filing
16 with the Secretary of State and each shall remain in effect for no
17 more than 180 days, by which time final regulations may be
18 adopted.

19 (3) The director shall consult with the Insurance Commissioner
20 to ensure consistency and uniformity in the development of
21 regulations under this subdivision.

22 (4) This subdivision shall become inoperative on March 1, 2016.

23 (p) For purposes of this section, the following definitions shall
24 apply:

25 (1) “Habilitative services” means medically necessary health
26 care services and health care devices that assist an individual in
27 partially or fully acquiring or improving skills and functioning and
28 that are necessary to address a health condition, to the maximum
29 extent practical. These services address the skills and abilities
30 needed for functioning in interaction with an individual’s
31 environment. Examples of health care services that are not
32 habilitative services include, but are not limited to, respite care,
33 day care, recreational care, residential treatment, social services,
34 custodial care, or education services of any kind, including, but
35 not limited to, vocational training. Habilitative services shall be
36 covered under the same terms and conditions applied to
37 rehabilitative services under the plan contract.

38 (2) (A) “Health benefits,” unless otherwise required to be
39 defined pursuant to federal rules, regulations, or guidance issued
40 pursuant to Section 1302(b) of PPACA, means health care items

1 or services for the diagnosis, cure, mitigation, treatment, or
2 prevention of illness, injury, disease, or a health condition,
3 including a behavioral health condition.

4 (B) “Health benefits” does not mean any cost-sharing
5 requirements such as copayments, coinsurance, or deductibles.

6 (3) “PPACA” means the federal Patient Protection and
7 Affordable Care Act (Public Law 111-148), as amended by the
8 federal Health Care and Education Reconciliation Act of 2010
9 (Public Law 111-152), and any rules, regulations, or guidance
10 issued thereunder.

11 (4) “Small group health care service plan contract” means a
12 group health care service plan contract issued to a small employer,
13 as defined in Section 1357.500.

14 ~~SEC. 7.~~

15 *SEC. 8.* Section 1367.006 of the Health and Safety Code is
16 amended to read:

17 1367.006. (a) This section shall apply to nongrandfathered
18 individual and group health care service plan contracts that provide
19 coverage for essential health benefits, as defined in Section
20 1367.005, and that are issued, amended, or renewed on or after
21 January 1, 2015.

22 (b) (1) For nongrandfathered health care service plan contracts
23 in the individual or small group markets, a health care service plan
24 contract, except a specialized health care service plan contract,
25 that is issued, amended, or renewed on or after January 1, 2015,
26 shall provide for a limit on annual out-of-pocket expenses for all
27 covered benefits that meet the definition of essential health benefits
28 in Section 1367.005, including out-of-network emergency care
29 consistent with Section 1371.4.

30 (2) For nongrandfathered health care service plan contracts in
31 the large group market, a health care service plan contract, except
32 a specialized health care service plan contract, that is issued,
33 amended, or renewed on or after January 1, 2015, shall provide
34 for a limit on annual out-of-pocket expenses for covered benefits,
35 including out-of-network emergency care consistent with Section
36 1371.4. This limit shall only apply to essential health benefits, as
37 defined in Section 1367.005, that are covered under the plan to
38 the extent that this provision does not conflict with federal law or
39 guidance on out-of-pocket maximums for nongrandfathered health
40 care service plan contracts in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g) For nongrandfathered health plan contracts in the group market, “plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, “plan year” means the calendar year.

(h) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

~~SEC. 8.~~

SEC. 9. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) No change in premium rates or changes in coverage stated in a group health care service plan contract shall become effective unless the plan has delivered in writing a notice

1 indicating the change or changes at least 60 days prior to the
2 contract renewal effective date.

3 (b) A health care service plan that declines to offer coverage to
4 or denies enrollment for a large group applying for coverage shall,
5 at the time of the denial of coverage, provide the applicant with
6 the specific reason or reasons for the decision in writing, in clear,
7 easily understandable language.

8 ~~SEC. 9.~~

9 *SEC. 10.* Section 1385.03 of the Health and Safety Code is
10 amended to read:

11 1385.03. (a) All health care service plans shall file with the
12 department all required rate information for individual and small
13 group health care service plan contracts at least 60 days prior to
14 implementing any rate change.

15 (b) A plan shall disclose to the department all of the following
16 for each individual and small group rate filing:

- 17 (1) Company name and contact information.
- 18 (2) Number of plan contract forms covered by the filing.
- 19 (3) Plan contract form numbers covered by the filing.
- 20 (4) Product type, such as a preferred provider organization or
21 health maintenance organization.
- 22 (5) Segment type.
- 23 (6) Type of plan involved, such as for profit or not for profit.
- 24 (7) Whether the products are opened or closed.
- 25 (8) Enrollment in each plan contract and rating form.
- 26 (9) Enrollee months in each plan contract form.
- 27 (10) Annual rate.
- 28 (11) Total earned premiums in each plan contract form.
- 29 (12) Total incurred claims in each plan contract form.
- 30 (13) Average rate ~~change~~ *increase* initially requested.
- 31 (14) Review category: initial filing for new product, filing for
32 existing product, or resubmission.
- 33 (15) Average rate of ~~change~~ *increase*.
- 34 (16) Effective date of rate ~~change~~ *increase*.
- 35 (17) Number of subscribers or enrollees affected by each plan
36 contract form.
- 37 (18) The plan's overall annual medical trend factor assumptions
38 in each rate filing for all benefits and by aggregate benefit category,
39 including hospital inpatient, hospital outpatient, physician services,
40 prescription drugs and other ancillary services, laboratory, and

1 radiology. A plan may provide aggregated additional data that
2 demonstrates or reasonably estimates year-to-year cost ~~changes~~
3 *increases* in specific benefit categories in the geographic regions
4 listed in Sections 1357.512 and 1399.855. A health plan that
5 exclusively contracts with no more than two medical groups in the
6 state to provide or arrange for professional medical services for
7 the enrollees of the plan shall instead disclose the amount of its
8 actual trend experience for the prior contract year by aggregate
9 benefit category, using benefit categories that are, to the maximum
10 extent possible, the same or similar to those used by other plans.

11 (19) The amount of the projected trend attributable to the use
12 of services, price inflation, or fees and risk for annual plan contract
13 trends by aggregate benefit category, such as hospital inpatient,
14 hospital outpatient, physician services, prescription drugs and other
15 ancillary services, laboratory, and radiology. A health plan that
16 exclusively contracts with no more than two medical groups in the
17 state to provide or arrange for professional medical services for
18 the enrollees of the plan shall instead disclose the amount of its
19 actual trend experience for the prior contract year by aggregate
20 benefit category, using benefit categories that are, to the maximum
21 extent possible, the same or similar to those used by other plans.

22 (20) A comparison of claims cost and rate of changes over time.

23 (21) Any changes in enrollee cost sharing over the prior year
24 associated with the submitted rate filing.

25 (22) Any changes in enrollee benefits over the prior year
26 associated with the submitted rate filing.

27 (23) The certification described in subdivision (b) of Section
28 1385.06.

29 (24) Any changes in administrative costs.

30 (25) Any other information required for rate review under
31 PPACA.

32 (c) A health care service plan subject to subdivision (a) shall
33 also disclose the following aggregate data for all rate filings
34 submitted under this section in the individual and small group
35 health plan markets:

36 (1) Number and percentage of rate filings reviewed by the
37 following:

38 (A) Plan year.

39 (B) Segment type.

40 (C) Product type.

1 (D) Number of subscribers.

2 (E) Number of covered lives affected.

3 (2) The plan's average rate ~~change~~ *increase* by the following
4 categories:

5 (A) Plan year.

6 (B) Segment type.

7 (C) Product type.

8 (3) Any cost containment and quality improvement efforts since
9 the plan's last rate filing for the same category of health benefit
10 plan. To the extent possible, the plan shall describe any significant
11 new health care cost containment and quality improvement efforts
12 and provide an estimate of potential savings together with an
13 estimated cost or savings for the projection period.

14 (d) The department may require all health care service plans to
15 submit all rate filings to the National Association of Insurance
16 Commissioners' System for Electronic Rate and Form Filing
17 (SERFF). Submission of the required rate filings to SERFF shall
18 be deemed to be filing with the department for purposes of
19 compliance with this section.

20 (e) A plan shall submit any other information required under
21 PPACA. A plan shall also submit any other information required
22 pursuant to any regulation adopted by the department to comply
23 with this article.

24 ~~SEC. 10. Section 1385.06 of the Health and Safety Code is~~
25 ~~amended to read:~~

26 ~~1385.06. (a) A filing submitted under this article shall be~~
27 ~~actuarially sound.~~

28 ~~(b) (1) The plan shall contract with an independent actuary or~~
29 ~~actuaries consistent with this section.~~

30 ~~(2) A filing submitted under this article shall include a~~
31 ~~certification by an independent actuary or actuarial firm that the~~
32 ~~rate change is reasonable or unreasonable and, if unreasonable,~~
33 ~~that the justification for the change is based on accurate and sound~~
34 ~~actuarial assumptions and methodologies. Unless PPACA requires~~
35 ~~a certification of actuarial soundness for each large group contract,~~
36 ~~a filing submitted under Section 1385.04 shall include a~~
37 ~~certification by an independent actuary, as described in this section,~~
38 ~~that the aggregate or average rate increase is based on accurate~~
39 ~~and sound actuarial assumptions and methodologies.~~

~~(3) The actuary or actuarial firm acting under paragraph (2) shall not be an affiliate or a subsidiary of, nor in any way owned or controlled by, a health care service plan or a trade association of health care service plans. A board member, director, officer, or employee of the actuary or actuarial firm shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of the actuary or actuarial firm.~~

~~(e) Nothing in this article shall be construed to permit the director to establish the rates charged subscribers and enrollees for covered health care services.~~

~~SEC. 11. Section 1385.07 of the Health and Safety Code is amended to read:~~

~~1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).~~

~~(b) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).~~

~~(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.~~

~~(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate change. The information shall include:~~

1 ~~(1) Justifications for any unreasonable rate changes, including~~
2 ~~all information and supporting documentation as to why the rate~~
3 ~~change is justified.~~

4 ~~(2) A plan's overall annual medical trend factor assumptions in~~
5 ~~each rate filing for all benefits.~~

6 ~~(3) A health plan's actual costs, by aggregate benefit category~~
7 ~~to include hospital inpatient, hospital outpatient, physician services,~~
8 ~~prescription drugs and other ancillary services, laboratory, and~~
9 ~~radiology.~~

10 ~~(4) The amount of the projected trend attributable to the use of~~
11 ~~services, price inflation, or fees and risk for annual plan contract~~
12 ~~trends by aggregate benefit category, such as hospital inpatient,~~
13 ~~hospital outpatient, physician services, prescription drugs and other~~
14 ~~ancillary services, laboratory, and radiology. A health plan that~~
15 ~~exclusively contracts with no more than two medical groups in the~~
16 ~~state to provide or arrange for professional medical services for~~
17 ~~the enrollees of the plan shall instead disclose the amount of its~~
18 ~~actual trend experience for the prior contract year by aggregate~~
19 ~~benefit category, using benefit categories that are, to the maximum~~
20 ~~extent possible, the same or similar to those used by other plans.~~

21 ~~SEC. 12.~~

22 ~~SEC. 11.~~ Section 1385.11 of the Health and Safety Code is
23 amended to read:

24 1385.11. (a) Whenever it appears to the department that any
25 person has engaged, or is about to engage, in any act or practice
26 constituting a violation of this article, including the filing of
27 inaccurate or unjustified rates or inaccurate or unjustified rate
28 information, the department may review the rate filing to ensure
29 compliance with the law.

30 (b) The department may review other filings.

31 (c) The department shall accept and post to its Internet Web site
32 any public comment on a rate ~~change~~ *increase* submitted to the
33 department during the 60-day period described in subdivision (d)
34 of Section 1385.07.

35 (d) The department shall report to the Legislature at least
36 quarterly on all unreasonable rate filings.

37 (e) The department shall post on its Internet Web site any
38 ~~modifications~~ *changes* submitted by the plan to the proposed rate
39 ~~change, increase,~~ including any documentation submitted by the
40 plan supporting those ~~modifications.~~ *changes.*

1 (f) If the director makes a decision that an unreasonable rate
2 ~~change~~ *increase* is not justified or that a rate filing contains
3 inaccurate information, the department shall post that decision on
4 its Internet Web site.

5 (g) Nothing in this article shall be construed to impair or impede
6 the department's authority to administer or enforce any other
7 provision of this chapter.

8 ~~SEC. 13.~~

9 *SEC. 12.* Section 1389.25 of the Health and Safety Code is
10 amended to read:

11 1389.25. (a) (1) This section shall apply only to a full service
12 health care service plan offering health coverage in the individual
13 market in California and shall not apply to a specialized health
14 care service plan, a health care service plan contract in the
15 Medi-Cal program (Chapter 7 (commencing with Section 14000)
16 of Part 3 of Division 9 of the Welfare and Institutions Code), a
17 health care service plan conversion contract offered pursuant to
18 Section 1373.6, a health care service plan contract in the Healthy
19 Families Program (Part 6.2 (commencing with Section 12693) of
20 Division 2 of the Insurance Code), or a health care service plan
21 contract offered to a federally eligible defined individual under
22 Article 4.6 (commencing with Section 1366.35).

23 (2) A local initiative, as defined in subdivision (v) of Section
24 53810 of Title 22 of the California Code of Regulations, that is
25 awarded a contract by the State Department of Health Care Services
26 pursuant to subdivision (b) of Section 53800 of Title 22 of the
27 California Code of Regulations, shall not be subject to this section
28 unless the plan offers coverage in the individual market to persons
29 not covered by Medi-Cal or the Healthy Families Program.

30 (b) (1) No change in the premium rate or coverage for an
31 individual plan contract shall become effective unless the plan has
32 delivered a written notice of the change at least 15 days prior to
33 the start of the annual enrollment period applicable to the contract
34 or 60 days prior to the effective date of the contract renewal,
35 whichever occurs earlier in the calendar year.

36 (2) The written notice required pursuant to paragraph (1) shall
37 be delivered to the individual contractholder at his or her last
38 address known to the plan. The notice shall state in italics and in
39 12-point type the actual dollar amount of the premium rate increase
40 and the specific percentage by which the current premium will be

1 increased. The notice shall describe in plain, understandable
2 English any changes in the plan design or any changes in benefits,
3 including a reduction in benefits or changes to waivers, exclusions,
4 or conditions, and highlight this information by printing it in italics.
5 The notice shall specify in a minimum of 10-point bold typeface,
6 the reason for a premium rate change or a change to the plan design
7 or benefits.

8 (c) If a plan rejects a dependent of a subscriber applying to be
9 added to the subscriber's individual grandfathered health plan,
10 rejects an applicant for a Medicare supplement plan contract due
11 to the applicant having end-stage renal disease, or offers an
12 individual grandfathered health plan to an applicant at a rate that
13 is higher than the standard rate, the plan shall inform the applicant
14 about the California Major Risk Medical Insurance Program
15 (MRMIP) (Part 6.5 (commencing with Section 12700) of Division
16 2 of the Insurance Code) and about the new coverage options, and
17 the potential for subsidized coverage, through Covered California.
18 The plan shall direct persons seeking more information to MRMIP,
19 Covered California, plan or policy representatives, insurance
20 agents, or an entity paid by Covered California to assist with health
21 coverage enrollment, such as a navigator or an assister.

22 (d) A notice provided pursuant to this section is a private and
23 confidential communication and, at the time of application, the
24 plan shall give the individual applicant the opportunity to designate
25 the address for receipt of the written notice in order to protect the
26 confidentiality of any personal or privileged information.

27 (e) For purposes of this section, the following definitions shall
28 apply:

29 (1) "Covered California" means the California Health Benefit
30 Exchange established pursuant to Section 100500 of the
31 Government Code.

32 (2) "Grandfathered health plan" has the same meaning as that
33 term is defined in Section 1251 of PPACA.

34 (3) "PPACA" means the federal Patient Protection and
35 Affordable Care Act (Public Law 111-148), as amended by the
36 federal Health Care and Education Reconciliation Act of 2010
37 (Public Law 111-152), and any rules, regulations, or guidance
38 issued pursuant to that law.

39 ~~SEC. 14. Section 1399.849 of the Health and Safety Code is~~
40 ~~amended to read:~~

~~1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).~~

~~(2) A plan shall allow the subscriber of an individual health benefit plan to add a dependent to the subscriber's plan at the option of the subscriber, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.~~

~~(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.~~

~~(c) (1) A plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.~~

~~(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.~~

~~(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:~~

~~(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:~~

~~(i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).~~

~~(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of~~

1 ~~minimum essential coverage” also includes loss of that coverage~~
2 ~~for a reason that is not due to the fault of the individual.~~

3 ~~(iii) “Loss of minimum essential coverage” does not include~~
4 ~~loss of that coverage due to the individual’s failure to pay~~
5 ~~premiums on a timely basis or situations allowing for a rescission,~~
6 ~~subject to clause (ii) and Sections 1389.7 and 1389.21.~~

7 ~~(B) He or she gains a dependent or becomes a dependent.~~

8 ~~(C) He or she is mandated to be covered as a dependent pursuant~~
9 ~~to a valid state or federal court order.~~

10 ~~(D) He or she has been released from incarceration.~~

11 ~~(E) His or her health coverage issuer substantially violated a~~
12 ~~material provision of the health coverage contract.~~

13 ~~(F) He or she gains access to new health benefit plans as a result~~
14 ~~of a permanent move.~~

15 ~~(G) He or she was receiving services from a contracting provider~~
16 ~~under another health benefit plan, as defined in Section 1399.845~~
17 ~~of this code or Section 10965 of the Insurance Code, for one of~~
18 ~~the conditions described in subdivision (e) of Section 1373.96 and~~
19 ~~that provider is no longer participating in the health benefit plan.~~

20 ~~(H) He or she demonstrates to the Exchange, with respect to~~
21 ~~health benefit plans offered through the Exchange, or to the~~
22 ~~department, with respect to health benefit plans offered outside~~
23 ~~the Exchange, that he or she did not enroll in a health benefit plan~~
24 ~~during the immediately preceding enrollment period available to~~
25 ~~the individual because he or she was misinformed that he or she~~
26 ~~was covered under minimum essential coverage.~~

27 ~~(I) He or she is a member of the reserve forces of the United~~
28 ~~States military returning from active duty or a member of the~~
29 ~~California National Guard returning from active duty service under~~
30 ~~Title 32 of the United States Code.~~

31 ~~(J) With respect to individual health benefit plans offered~~
32 ~~through the Exchange, in addition to the triggering events listed~~
33 ~~in this paragraph, any other events listed in Section 155.420(d) of~~
34 ~~Title 45 of the Code of Federal Regulations.~~

35 ~~(2) With respect to individual health benefit plans offered~~
36 ~~outside the Exchange, an individual shall have 60 days from the~~
37 ~~date of a triggering event identified in paragraph (1) to apply for~~
38 ~~coverage from a health care service plan subject to this section.~~
39 ~~With respect to individual health benefit plans offered through the~~
40 ~~Exchange, an individual shall have 60 days from the date of a~~

1 triggering event identified in paragraph (1) to select a plan offered
2 through the Exchange, unless a longer period is provided in Part
3 155 (commencing with Section 155.10) of Subchapter B of Subtitle
4 A of Title 45 of the Code of Federal Regulations.

5 (e) ~~With respect to individual health benefit plans offered~~
6 ~~through the Exchange, the effective date of coverage required~~
7 ~~pursuant to this section shall be consistent with the dates specified~~
8 ~~in Section 155.410 or 155.420 of Title 45 of the Code of Federal~~
9 ~~Regulations, as applicable. A dependent who is a registered~~
10 ~~domestic partner pursuant to Section 297 of the Family Code shall~~
11 ~~have the same effective date of coverage as a spouse.~~

12 (f) ~~With respect to individual health benefit plans offered outside~~
13 ~~the Exchange, the following provisions shall apply:~~

14 (1) ~~After an individual submits a completed application form~~
15 ~~for a plan contract, the health care service plan shall, within 30~~
16 ~~days, notify the individual of the individual's actual premium~~
17 ~~charges for that plan established in accordance with Section~~
18 ~~1399.855. The individual shall have 30 days in which to exercise~~
19 ~~the right to buy coverage at the quoted premium charges.~~

20 (2) ~~With respect to an individual health benefit plan for which~~
21 ~~an individual applies during the initial open enrollment period~~
22 ~~described in subdivision (e), when the subscriber submits a~~
23 ~~premium payment, based on the quoted premium charges, and that~~
24 ~~payment is delivered or postmarked, whichever occurs earlier, by~~
25 ~~December 15, 2013, coverage under the individual health benefit~~
26 ~~plan shall become effective no later than January 1, 2014. When~~
27 ~~that payment is delivered or postmarked within the first 15 days~~
28 ~~of any subsequent month, coverage shall become effective no later~~
29 ~~than the first day of the following month. When that payment is~~
30 ~~delivered or postmarked between December 16, 2013, and~~
31 ~~December 31, 2013, inclusive, or after the 15th day of any~~
32 ~~subsequent month, coverage shall become effective no later than~~
33 ~~the first day of the second month following delivery or postmark~~
34 ~~of the payment.~~

35 (3) ~~With respect to an individual health benefit plan for which~~
36 ~~an individual applies during the annual open enrollment period~~
37 ~~described in subdivision (e), when the individual submits a~~
38 ~~premium payment, based on the quoted premium charges, and that~~
39 ~~payment is delivered or postmarked, whichever occurs later, by~~
40 ~~December 15, coverage shall become effective as of the following~~

1 ~~January 1. When that payment is delivered or postmarked within~~
2 ~~the first 15 days of any subsequent month, coverage shall become~~
3 ~~effective no later than the first day of the following month. When~~
4 ~~that payment is delivered or postmarked between December 16~~
5 ~~and December 31, inclusive, or after the 15th day of any subsequent~~
6 ~~month, coverage shall become effective no later than the first day~~
7 ~~of the second month following delivery or postmark of the~~
8 ~~payment.~~

9 ~~(4) With respect to an individual health benefit plan for which~~
10 ~~an individual applies during a special enrollment period described~~
11 ~~in subdivision (d), the following provisions shall apply:~~

12 ~~(A) When the individual submits a premium payment, based~~
13 ~~on the quoted premium charges, and that payment is delivered or~~
14 ~~postmarked, whichever occurs earlier, within the first 15 days of~~
15 ~~the month, coverage under the plan shall become effective no later~~
16 ~~than the first day of the following month. When the premium~~
17 ~~payment is neither delivered nor postmarked until after the 15th~~
18 ~~day of the month, coverage shall become effective no later than~~
19 ~~the first day of the second month following delivery or postmark~~
20 ~~of the payment.~~

21 ~~(B) Notwithstanding subparagraph (A), in the case of a birth,~~
22 ~~adoption, or placement for adoption, the coverage shall be effective~~
23 ~~on the date of birth, adoption, or placement for adoption.~~

24 ~~(C) Notwithstanding subparagraph (A), in the case of marriage~~
25 ~~or becoming a registered domestic partner or in the case where a~~
26 ~~qualified individual loses minimum essential coverage, the~~
27 ~~coverage effective date shall be the first day of the month following~~
28 ~~the date the plan receives the request for special enrollment.~~

29 ~~(g) (1) A health care service plan shall not establish rules for~~
30 ~~eligibility, including continued eligibility, of any individual to~~
31 ~~enroll under the terms of an individual health benefit plan based~~
32 ~~on any of the following factors:~~

33 ~~(A) Health status.~~

34 ~~(B) Medical condition, including physical and mental illnesses.~~

35 ~~(C) Claims experience.~~

36 ~~(D) Receipt of health care.~~

37 ~~(E) Medical history.~~

38 ~~(F) Genetic information.~~

39 ~~(G) Evidence of insurability, including conditions arising out~~
40 ~~of acts of domestic violence.~~

1 (H) Disability.

2 (I) Any other health status-related factor as determined by any
3 federal regulations, rules, or guidance issued pursuant to Section
4 2705 of the federal Public Health Service Act.

5 (2) Notwithstanding Section 1389.1, a health care service plan
6 shall not require an individual applicant or his or her dependent
7 to fill out a health assessment or medical questionnaire prior to
8 enrollment under an individual health benefit plan. A health care
9 service plan shall not acquire or request information that relates
10 to a health status-related factor from the applicant or his or her
11 dependent or any other source prior to enrollment of the individual.

12 (h) (1) A health care service plan shall consider as a single risk
13 pool for rating purposes in the individual market the claims
14 experience of all insureds and all enrollees in all nongrandfathered
15 individual health benefit plans offered by that health care service
16 plan in this state, whether offered as health care service plan
17 contracts or individual health insurance policies, including those
18 insureds and enrollees who enroll in individual coverage through
19 the Exchange and insureds and enrollees who enroll in individual
20 coverage outside of the Exchange. Student health insurance
21 coverage, as that coverage is defined in Section 147.145(a) of Title
22 45 of the Code of Federal Regulations, shall not be included in a
23 health care service plan's single risk pool for individual coverage.

24 (2) Each calendar year, a health care service plan shall establish
25 an index rate for the individual market in the state based on the
26 total combined claims costs for providing essential health benefits;
27 as defined pursuant to Section 1302 of PPACA, within the single
28 risk pool required under paragraph (1). The index rate shall be
29 adjusted on a marketwide basis based on the total expected
30 marketwide payments and charges under the risk adjustment and
31 reinsurance programs established for the state pursuant to Sections
32 1343 and 1341 of PPACA and Exchange user fees, as described
33 in subdivision (d) of Section 156.80 of Title 45 of the Code of
34 Federal Regulations. The premium rate for all of the health benefit
35 plans in the individual market within the single risk pool required
36 under paragraph (1) shall use the applicable marketwide adjusted
37 index rate, subject only to the adjustments permitted under
38 paragraph (3).

~~(3) A health care service plan may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:~~

~~(A) The actuarial value and cost-sharing design of the health benefit plan.~~

~~(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.~~

~~(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.~~

~~(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.~~

~~(E) Administrative costs, excluding user fees required by the Exchange.~~

~~(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.~~

~~(j) This section shall not apply to a grandfathered health plan.~~

~~(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment.~~

SEC. 13. Section 1399.849 of the Health and Safety Code is amended to read:

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

1 (2) A plan shall allow the subscriber of an individual health
2 benefit plan to add a dependent to the subscriber's plan at the
3 option of the subscriber, consistent with the open enrollment,
4 annual enrollment, and special enrollment period requirements in
5 this section.

6 (b) An individual health benefit plan issued, amended, or
7 renewed on or after January 1, 2014, shall not impose any
8 preexisting condition provision upon any individual.

9 (c) (1) A plan shall provide an initial open enrollment period
10 from October 1, 2013, to March 31, 2014, inclusive, an annual
11 enrollment period for the policy year beginning on January 1, 2015,
12 from November 15, 2014, to February 15, 2015, inclusive, and
13 annual enrollment periods for policy years beginning on or after
14 January 1, 2016, from October 15 to December 7, inclusive, of the
15 preceding calendar year.

16 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code
17 of Federal Regulations, for individuals enrolled in noncalendar
18 year individual health plan contracts, a plan shall also provide a
19 limited open enrollment period beginning on the date that is 30
20 calendar days prior to the date the policy year ends in 2014.

21 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
22 a plan shall allow an individual to enroll in or change individual
23 health benefit plans as a result of the following triggering events:

24 (A) He or she or his or her dependent loses minimum essential
25 coverage. For purposes of this paragraph, the following definitions
26 shall apply:

27 (i) "Minimum essential coverage" has the same meaning as that
28 term is defined in subsection (f) of Section 5000A of the Internal
29 Revenue Code (26 U.S.C. Sec. 5000A).

30 (ii) "Loss of minimum essential coverage" includes, but is not
31 limited to, loss of that coverage due to the circumstances described
32 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
33 Code of Federal Regulations and the circumstances described in
34 Section 1163 of Title 29 of the United States Code. "Loss of
35 minimum essential coverage" also includes loss of that coverage
36 for a reason that is not due to the fault of the individual.

37 (iii) "Loss of minimum essential coverage" does not include
38 loss of that coverage due to the individual's failure to pay
39 premiums on a timely basis or situations allowing for a rescission,
40 subject to clause (ii) and Sections 1389.7 and 1389.21.

1 (B) He or she gains a dependent or becomes a dependent.

2 (C) He or she is mandated to be covered as a dependent pursuant
3 to a valid state or federal court order.

4 (D) He or she has been released from incarceration.

5 (E) His or her health coverage issuer substantially violated a
6 material provision of the health coverage contract.

7 (F) He or she gains access to new health benefit plans as a result
8 of a permanent move.

9 (G) He or she was receiving services from a contracting provider
10 under another health benefit plan, as defined in Section 1399.845
11 *of this code* or Section 10965 of the Insurance Code, for one of
12 the conditions described in subdivision (c) of Section 1373.96 and
13 that provider is no longer participating in the health benefit plan.

14 (H) He or she demonstrates to the Exchange, with respect to
15 health benefit plans offered through the Exchange, or to the
16 department, with respect to health benefit plans offered outside
17 the Exchange, that he or she did not enroll in a health benefit plan
18 during the immediately preceding enrollment period available to
19 the individual because he or she was misinformed that he or she
20 was covered under minimum essential coverage.

21 (I) He or she is a member of the reserve forces of the United
22 States military returning from active duty or a member of the
23 California National Guard returning from active duty service under
24 Title 32 of the United States Code.

25 (J) With respect to individual health benefit plans offered
26 through the Exchange, in addition to the triggering events listed
27 in this paragraph, any other events listed in Section 155.420(d) of
28 Title 45 of the Code of Federal Regulations.

29 (2) With respect to individual health benefit plans offered
30 outside the Exchange, an individual shall have 60 days from the
31 date of a triggering event identified in paragraph (1) to apply for
32 coverage from a health care service plan subject to this section.
33 With respect to individual health benefit plans offered through the
34 Exchange, an individual shall have 60 days from the date of a
35 triggering event identified in paragraph (1) to select a plan offered
36 through the Exchange, unless a longer period is provided in Part
37 155 (commencing with Section 155.10) of Subchapter B of Subtitle
38 A of Title 45 of the Code of Federal Regulations.

39 (e) With respect to individual health benefit plans offered
40 through the Exchange, the effective date of coverage required

1 pursuant to this section shall be consistent with the dates specified
2 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
3 Regulations, as applicable. A dependent who is a registered
4 domestic partner pursuant to Section 297 of the Family Code shall
5 have the same effective date of coverage as a spouse.

6 (f) With respect to individual health benefit plans offered outside
7 the Exchange, the following provisions shall apply:

8 (1) After an individual submits a completed application form
9 for a plan contract, the health care service plan shall, within 30
10 days, notify the individual of the individual's actual premium
11 charges for that plan established in accordance with Section
12 1399.855. The individual shall have 30 days in which to exercise
13 the right to buy coverage at the quoted premium charges.

14 (2) With respect to an individual health benefit plan for which
15 an individual applies during the initial open enrollment period
16 described in subdivision (c), when the subscriber submits a
17 premium payment, based on the quoted premium charges, and that
18 payment is delivered or postmarked, whichever occurs earlier, by
19 December 15, 2013, coverage under the individual health benefit
20 plan shall become effective no later than January 1, 2014. When
21 that payment is delivered or postmarked within the first 15 days
22 of any subsequent month, coverage shall become effective no later
23 than the first day of the following month. When that payment is
24 delivered or postmarked between December 16, 2013, and
25 December 31, 2013, inclusive, or after the 15th day of any
26 subsequent month, coverage shall become effective no later than
27 the first day of the second month following delivery or postmark
28 of the payment.

29 (3) With respect to an individual health benefit plan for which
30 an individual applies during the annual open enrollment period
31 described in subdivision (c), when the individual submits a
32 premium payment, based on the quoted premium charges, and that
33 payment is delivered or postmarked, whichever occurs later, by
34 December 15, coverage shall become effective as of the following
35 January 1. When that payment is delivered or postmarked within
36 the first 15 days of any subsequent month, coverage shall become
37 effective no later than the first day of the following month. When
38 that payment is delivered or postmarked between December 16
39 and December 31, inclusive, or after the 15th day of any subsequent
40 month, coverage shall become effective no later than the first day

1 of the second month following delivery or postmark of the
2 payment.

3 (4) With respect to an individual health benefit plan for which
4 an individual applies during a special enrollment period described
5 in subdivision (d), the following provisions shall apply:

6 (A) When the individual submits a premium payment, based
7 on the quoted premium charges, and that payment is delivered or
8 postmarked, whichever occurs earlier, within the first 15 days of
9 the month, coverage under the plan shall become effective no later
10 than the first day of the following month. When the premium
11 payment is neither delivered nor postmarked until after the 15th
12 day of the month, coverage shall become effective no later than
13 the first day of the second month following delivery or postmark
14 of the payment.

15 (B) Notwithstanding subparagraph (A), in the case of a birth,
16 adoption, or placement for adoption, the coverage shall be effective
17 on the date of birth, adoption, or placement for adoption.

18 (C) Notwithstanding subparagraph (A), in the case of marriage
19 or becoming a registered domestic partner or in the case where a
20 qualified individual loses minimum essential coverage, the
21 coverage effective date shall be the first day of the month following
22 the date the plan receives the request for special enrollment.

23 (g) (1) A health care service plan shall not establish rules for
24 eligibility, including continued eligibility, of any individual to
25 enroll under the terms of an individual health benefit plan based
26 on any of the following factors:

27 (A) Health status.

28 (B) Medical condition, including physical and mental illnesses.

29 (C) Claims experience.

30 (D) Receipt of health care.

31 (E) Medical history.

32 (F) Genetic information.

33 (G) Evidence of insurability, including conditions arising out
34 of acts of domestic violence.

35 (H) Disability.

36 (I) Any other health status-related factor as determined by any
37 federal regulations, rules, or guidance issued pursuant to Section
38 2705 of the federal Public Health Service Act.

39 (2) Notwithstanding Section 1389.1, a health care service plan
40 shall not require an individual applicant or his or her dependent

1 to fill out a health assessment or medical questionnaire prior to
2 enrollment under an individual health benefit plan. A health care
3 service plan shall not acquire or request information that relates
4 to a health status-related factor from the applicant or his or her
5 dependent or any other source prior to enrollment of the individual.

6 (h) (1) A health care service plan shall consider as a single risk
7 pool for rating purposes in the individual market the claims
8 experience of all insureds and *all* enrollees in all nongrandfathered
9 individual health benefit plans offered by that health care service
10 plan in this state, whether offered as health care service plan
11 contracts or individual health insurance policies, including those
12 insureds and enrollees who enroll in individual coverage through
13 the Exchange and insureds and enrollees who enroll in individual
14 coverage outside of the Exchange. Student health insurance
15 coverage, as that coverage is defined in Section 147.145(a) of Title
16 45 of the Code of Federal Regulations, shall not be included in a
17 health care service plan's single risk pool for individual coverage.

18 (2) Each calendar year, a health care service plan shall establish
19 an index rate for the individual market in the state based on the
20 total combined claims costs for providing essential health benefits,
21 as defined pursuant to Section 1302 of PPACA, within the single
22 risk pool required under paragraph (1). The index rate shall be
23 adjusted on a marketwide basis based on the total expected
24 marketwide payments and charges under the risk adjustment and
25 reinsurance programs established for the state pursuant to Sections
26 1343 and 1341 of PPACA *and Exchange user fees, as described*
27 *in subdivision (d) of Section 156.80 of Title 45 of the Code of*
28 *Federal Regulations*. The premium rate for all of the ~~health care~~
29 ~~service plan's~~ health benefit plans in the individual market *within*
30 *the single risk pool required under paragraph (1)* shall use the
31 applicable *marketwide adjusted* index rate, ~~as adjusted for total~~
32 ~~expected marketwide payments and charges under the risk~~
33 ~~adjustment and reinsurance programs established for the state~~
34 ~~pursuant to Sections 1343 and 1341 of PPACA~~, subject only to
35 the adjustments permitted under paragraph (3).

36 (3) A health care service plan may vary premium rates for a
37 particular health benefit plan from its index rate based only on the
38 following actuarially justified plan-specific factors:

39 (A) The actuarial value and cost-sharing design of the health
40 benefit plan.

1 (B) The health benefit plan's provider network, delivery system
2 characteristics, and utilization management practices.

3 (C) The benefits provided under the health benefit plan that are
4 in addition to the essential health benefits, as defined pursuant to
5 Section 1302 of PPACA and Section 1367.005. These additional
6 benefits shall be pooled with similar benefits within the single risk
7 pool required under paragraph (1) and the claims experience from
8 those benefits shall be utilized to determine rate variations for
9 plans that offer those benefits in addition to essential health
10 benefits.

11 (D) With respect to catastrophic plans, as described in subsection
12 (e) of Section 1302 of PPACA, the expected impact of the specific
13 eligibility categories for those plans.

14 (E) Administrative costs, excluding user fees required by the
15 Exchange.

16 (i) This section shall only apply with respect to individual health
17 benefit plans for policy years on or after January 1, 2014.

18 (j) This section shall not apply to ~~an individual health benefit~~
19 ~~plan that is a grandfathered health plan.~~

20 (k) If Section 5000A of the Internal Revenue Code, as added
21 by Section 1501 of PPACA, is repealed or amended to no longer
22 apply to the individual market, as defined in Section 2791 of the
23 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),
24 subdivisions (a), (b), and (g) shall become inoperative 12 months
25 after that repeal or amendment.

26 ~~SEC. 15.~~

27 *SEC. 14.* Section 10112.27 of the Insurance Code is amended
28 to read:

29 10112.27. (a) An individual or small group health insurance
30 policy issued, amended, or renewed on or after January 1, 2014,
31 shall, at a minimum, include coverage for essential health benefits
32 pursuant to PPACA and as outlined in this section. This section
33 shall exclusively govern what benefits a health insurer must cover
34 as essential health benefits. For purposes of this section, "essential
35 health benefits" means all of the following:

36 (1) Health benefits within the categories identified in Section
37 1302(b) of PPACA: ambulatory patient services, emergency
38 services, hospitalization, maternity and newborn care, mental health
39 and substance use disorder services, including behavioral health
40 treatment, prescription drugs, rehabilitative and habilitative services

1 and devices, laboratory services, preventive and wellness services
2 and chronic disease management, and pediatric services, including
3 oral and vision care.

4 (2) (A) The health benefits covered by the Kaiser Foundation
5 Health Plan Small Group HMO 30 plan (federal health product
6 identification number 40513CA035) as this plan was offered during
7 the first quarter of 2012, as follows, regardless of whether the
8 benefits are specifically referenced in the plan contract or evidence
9 of coverage for that plan:

10 (i) Medically necessary basic health care services, as defined
11 in subdivision (b) of Section 1345 of the Health and Safety Code
12 and in Section 1300.67 of Title 28 of the California Code of
13 Regulations.

14 (ii) The health benefits mandated to be covered by the plan
15 pursuant to statutes enacted before December 31, 2011, as
16 described in the following sections of the Health and Safety Code:
17 Sections 1367.002, 1367.06, and 1367.35 (preventive services for
18 children); Section 1367.25 (prescription drug coverage for
19 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46
20 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha
21 fetoprotein testing); Section 1367.6 (breast cancer screening);
22 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62
23 (maternity hospital stay); Section 1367.63 (reconstructive surgery);
24 Section 1367.635 (mastectomies); Section 1367.64 (prostate
25 cancer); Section 1367.65 (mammography); Section 1367.66
26 (cervical cancer); Section 1367.665 (cancer screening tests);
27 Section 1367.67 (osteoporosis); Section 1367.68 (surgical
28 procedures for jaw bones); Section 1367.71 (anesthesia for dental);
29 Section 1367.9 (conditions attributable to diethylstilbestrol);
30 Section 1368.2 (hospice care); Section 1370.6 (cancer clinical
31 trials); Section 1371.5 (emergency response ambulance or
32 ambulance transport services); subdivision (b) of Section 1373
33 (sterilization operations or procedures); Section 1373.4 (inpatient
34 hospital and ambulatory maternity); Section 1374.56
35 (phenylketonuria); Section 1374.17 (organ transplants for HIV);
36 Section 1374.72 (mental health parity); and Section 1374.73
37 (autism/behavioral health treatment).

38 (iii) Any other benefits mandated to be covered by the plan
39 pursuant to statutes enacted before December 31, 2011, as
40 described in those statutes.

1 (iv) The health benefits covered by the plan that are not
2 otherwise required to be covered under Chapter 2.2 (commencing
3 with Section 1340) of Division 2 of the Health and Safety Code,
4 to the extent otherwise required pursuant to Sections 1367.18,
5 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
6 and Safety Code, and Section 1300.67.24 of Title 28 of the
7 California Code of Regulations.

8 (v) Any other health benefits covered by the plan that are not
9 otherwise required to be covered under Chapter 2.2 (commencing
10 with Section 1340) of Division 2 of the Health and Safety Code.

11 (B) Where there are any conflicts or omissions in the plan
12 identified in subparagraph (A) as compared with the requirements
13 for health benefits under Chapter 2.2 (commencing with Section
14 1340) of Division 2 of the Health and Safety Code that were
15 enacted prior to December 31, 2011, the requirements of Chapter
16 2.2 (commencing with Section 1340) of Division 2 of the Health
17 and Safety Code shall be controlling, except as otherwise specified
18 in this section.

19 (C) Notwithstanding subparagraph (B) or any other provision
20 of this section, the home health services benefits covered under
21 the plan identified in subparagraph (A) shall be deemed to not be
22 in conflict with Chapter 2.2 (commencing with Section 1340) of
23 Division 2 of the Health and Safety Code.

24 (D) For purposes of this section, the Paul Wellstone and Pete
25 Domenici Mental Health Parity and Addiction Equity Act of 2008
26 (Public Law 110-343) shall apply to a policy subject to this section.
27 Coverage of mental health and substance use disorder services
28 pursuant to this paragraph, along with any scope and duration
29 limits imposed on the benefits, shall be in compliance with the
30 Paul Wellstone and Pete Domenici Mental Health Parity and
31 Addiction Equity Act of 2008 (Public Law 110-343), and all rules,
32 regulations, and guidance issued pursuant to Section 2726 of the
33 federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

34 (3) With respect to habilitative services, in addition to any
35 habilitative services identified in paragraph (2), coverage shall
36 also be provided as required by federal rules, regulations, or
37 guidance issued pursuant to Section 1302(b) of PPACA.
38 Habilitative services shall be covered under the same terms and
39 conditions applied to rehabilitative services under the policy.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children’s Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) No health insurer, or its agent, producer, or representative, shall issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be

1 enforced in the same manner as Section 790.03, including through
2 the means specified in Sections 790.035 and 790.05.

3 (f) This section shall apply regardless of whether the policy is
4 offered inside or outside the California Health Benefit Exchange
5 created by Section 100500 of the Government Code.

6 (g) Nothing in this section shall be construed to exempt a health
7 insurer or a health insurance policy from meeting other applicable
8 requirements of law.

9 (h) This section shall not be construed to prohibit a policy from
10 covering additional benefits, including, but not limited to, spiritual
11 care services that are tax deductible under Section 213 of the
12 Internal Revenue Code.

13 (i) Subdivision (a) shall not apply to any of the following:

14 (1) A policy that provides excepted benefits as described in
15 Sections 2722 and 2791 of the federal Public Health Service Act
16 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

17 (2) A policy that qualifies as a grandfathered health plan under
18 Section 1251 of PPACA or any binding rules, regulation, or
19 guidance issued pursuant to that section.

20 (j) Nothing in this section shall be implemented in a manner
21 that conflicts with a requirement of PPACA.

22 (k) This section shall be implemented only to the extent essential
23 health benefits are required pursuant to PPACA.

24 (l) An essential health benefit is required to be provided under
25 this section only to the extent that federal law does not require the
26 state to defray the costs of the benefit.

27 (m) Nothing in this section shall obligate the state to incur costs
28 for the coverage of benefits that are not essential health benefits
29 as defined in this section.

30 (n) An insurer is not required to cover, under this section,
31 changes to health benefits that are the result of statutes enacted on
32 or after December 31, 2011.

33 (o) (1) The commissioner may adopt emergency regulations
34 implementing this section. The commissioner may, on a one-time
35 basis, readopt any emergency regulation authorized by this section
36 that is the same as, or substantially equivalent to, an emergency
37 regulation previously adopted under this section.

38 (2) The initial adoption of emergency regulations implementing
39 this section and the readoption of emergency regulations authorized
40 by this subdivision shall be deemed an emergency and necessary

1 for the immediate preservation of the public peace, health, safety,
2 or general welfare. The initial emergency regulations and the
3 readoption of emergency regulations authorized by this section
4 shall be submitted to the Office of Administrative Law for filing
5 with the Secretary of State and each shall remain in effect for no
6 more than 180 days, by which time final regulations may be
7 adopted.

8 (3) The commissioner shall consult with the Director of the
9 Department of Managed Health Care to ensure consistency and
10 uniformity in the development of regulations under this
11 subdivision.

12 (4) This subdivision shall become inoperative on March 1, 2016.

13 (p) Nothing in this section shall impose on health insurance
14 policies the cost sharing or network limitations of the plans
15 identified in subdivision (a) except to the extent otherwise required
16 to comply with provisions of this code, including this section, and
17 as otherwise applicable to all health insurance policies offered to
18 individuals and small groups.

19 (q) For purposes of this section, the following definitions shall
20 apply:

21 (1) “Habilitative services” means medically necessary health
22 care services and health care devices that assist an individual in
23 partially or fully acquiring or improving skills and functioning and
24 that are necessary to address a health condition, to the maximum
25 extent practical. These services address the skills and abilities
26 needed for functioning in interaction with an individual’s
27 environment. Examples of health care services that are not
28 habilitative services include, but are not limited to, respite care,
29 day care, recreational care, residential treatment, social services,
30 custodial care, or education services of any kind, including, but
31 not limited to, vocational training. Habilitative services shall be
32 covered under the same terms and conditions applied to
33 rehabilitative services under the policy.

34 (2) (A) “Health benefits,” unless otherwise required to be
35 defined pursuant to federal rules, regulations, or guidance issued
36 pursuant to Section 1302(b) of PPACA, means health care items
37 or services for the diagnosis, cure, mitigation, treatment, or
38 prevention of illness, injury, disease, or a health condition,
39 including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) “Small group health insurance policy” means a group health insurance policy issued to a small employer, as defined in Section 10753.

~~SEC. 16.~~

SEC. 15. Section 10112.28 of the Insurance Code is amended to read:

10112.28. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27, including out-of-network emergency care.

(2) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health insurance policies in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health

benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.

(g) For nongrandfathered health insurance policies in the group market, “policy year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, “policy year” means the calendar year.

(h) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

~~SEC. 17.~~

SEC. 16. Section 10112.3 of the Insurance Code, as amended by Section 11 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) “Exchange” means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) “Federal act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010

1 (Public Law 111-152), and any amendments to, or regulations or
2 guidance issued under, those acts.

3 (3) “Qualified health plan” has the same meaning as that term
4 is defined in Section 1301 of the federal act.

5 (4) “Small employer” has the same meaning as that term is
6 defined in Section 10753.

7 (b) (1) Health insurers participating in the individual market
8 of the Exchange shall fairly and affirmatively offer, market, and
9 sell in the individual market of the Exchange at least one product
10 within each of the five levels of coverage contained in subsections
11 (d) and (e) of Section 1302 of the federal act. Health insurers
12 participating in the Small Business Health Options Program (SHOP
13 Program) of the Exchange, established pursuant to subdivision
14 (m) of Section 100504 of the Government Code, shall fairly and
15 affirmatively offer, market, and sell in the SHOP Program at least
16 one product within each of the four levels of coverage contained
17 in subsection (d) of Section 1302 of the federal act.

18 (2) The board established under Section 100500 of the
19 Government Code may require insurers to sell additional products
20 within each of the levels of coverage identified in paragraph (1).

21 (3) This subdivision shall not apply to an insurer that solely
22 offers supplemental coverage in the Exchange under paragraph
23 (10) of subdivision (a) of Section 100504 of the Government Code.
24 This subdivision shall not apply to a bridge plan product of a
25 Medi-Cal managed care plan that contracts with the State
26 Department of Health Care Services pursuant to Section 14005.70
27 of the Welfare and Institutions Code and that meets the
28 requirements of Section 100504.5 of the Government Code, to the
29 extent approved by the appropriate federal agency.

30 (c) (1) Health insurers participating in the Exchange that sell
31 any products outside the Exchange shall do both of the following:

32 (A) Fairly and affirmatively offer, market, and sell all products
33 made available to individuals in the Exchange to individuals
34 purchasing coverage outside the Exchange.

35 (B) Fairly and affirmatively offer, market, and sell all products
36 made available to small employers in the Exchange to small
37 employers purchasing coverage outside the Exchange.

38 (2) For purposes of this subdivision, “product” does not include
39 contracts entered into pursuant to Part 6.2 (commencing with
40 Section 12693) of Division 2 between the Managed Risk Medical

1 Insurance Board and health insurers for enrolled Healthy Families
2 beneficiaries or to contracts entered into pursuant to Chapter 7
3 (commencing with Section 14000) of, or Chapter 8 (commencing
4 with Section 14200) of, Part 3 of Division 9 of the Welfare and
5 Institutions Code between the State Department of Health Care
6 Services and health insurers for enrolled Medi-Cal beneficiaries
7 or for contracts with bridge plan products that meet the
8 requirements of Section 100504.5 of the Government Code.

9 (d) (1) Commencing January 1, 2014, a health insurer shall,
10 with respect to individual policies that cover hospital, medical, or
11 surgical benefits, only sell the five levels of coverage contained
12 in subsections (d) and (e) of Section 1302 of the federal act, except
13 that a health insurer that does not participate in the Exchange shall,
14 with respect to individual policies that cover hospital, medical, or
15 surgical benefits, only sell the four levels of coverage contained
16 in subsection (d) of Section 1302 of the federal act.

17 (2) Commencing January 1, 2014, a health insurer shall, with
18 respect to small employer policies that cover hospital, medical, or
19 surgical expenses, only sell the four levels of coverage contained
20 in subsection (d) of Section 1302 of the federal act.

21 (e) Commencing January 1, 2014, a health insurer that does not
22 participate in the Exchange shall, with respect to individual or
23 small employer policies that cover hospital, medical, or surgical
24 expenses, offer at least one standardized product that has been
25 designated by the Exchange in each of the four levels of coverage
26 contained in subsection (d) of Section 1302 of the federal act. This
27 subdivision shall only apply if the board of the Exchange exercises
28 its authority under subdivision (c) of Section 100504 of the
29 Government Code. Nothing in this subdivision shall require an
30 insurer that does not participate in the Exchange to offer
31 standardized products in the small employer market if the insurer
32 only sells products in the individual market. Nothing in this
33 subdivision shall require an insurer that does not participate in the
34 Exchange to offer standardized products in the individual market
35 if the insurer only sells products in the small employer market.
36 This subdivision shall not be construed to prohibit the insurer from
37 offering other products provided that it complies with subdivision
38 (d).

39 (f) For purposes of this section, a bridge plan product shall mean
40 an individual health benefit plan, as defined in subdivision (a) of

1 Section 10198.6 that is offered by a health insurer that contracts
2 with the Exchange pursuant to Section 100504.5 of the Government
3 Code.

4 (g) This section shall become inoperative on the October 1 that
5 is five years after the date that federal approval of the bridge plan
6 option occurs, and, as of the second January 1 thereafter, is
7 repealed, unless a later enacted statute that is enacted before that
8 date deletes or extends the dates on which it becomes inoperative
9 and is repealed.

10 ~~SEC. 18.~~

11 *SEC. 17.* Section 10112.3 of the Insurance Code, as added by
12 Section 12 of Chapter 5 of the First Extraordinary Session of the
13 Statutes of 2013, is amended to read:

14 10112.3. (a) For purposes of this section, the following
15 definitions shall apply:

16 (1) “Exchange” means the California Health Benefit Exchange
17 established in Title 22 (commencing with Section 100500) of the
18 Government Code.

19 (2) “Federal act” means the federal Patient Protection and
20 Affordable Care Act (Public Law 111-148), as amended by the
21 federal Health Care and Education Reconciliation Act of 2010
22 (Public Law 111-152), and any amendments to, or regulations or
23 guidance issued under, those acts.

24 (3) “Qualified health plan” has the same meaning as that term
25 is defined in Section 1301 of the federal act.

26 (4) “Small employer” has the same meaning as that term is
27 defined in Section 10753.

28 (b) (1) Health insurers participating in the individual market
29 of the Exchange shall fairly and affirmatively offer, market, and
30 sell in the individual market of the Exchange at least one product
31 within each of the five levels of coverage contained in subsections
32 (d) and (e) of Section 1302 of the federal act. Health insurers
33 participating in the Small Business Health Options Program (SHOP
34 Program) of the Exchange, established pursuant to subdivision
35 (m) of Section 100504 of the Government Code, shall fairly and
36 affirmatively offer, market, and sell in the SHOP Program at least
37 one product within each of the four levels of coverage contained
38 in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require insurers to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health insurers for enrolled Medi-Cal beneficiaries.

(d) (1) Commencing January 1, 2014, a health insurer shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health insurer shall, with respect to small employer policies that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to individual or small employer policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage

1 contained in subsection (d) of Section 1302 of the federal act. This
2 subdivision shall only apply if the board of the Exchange exercises
3 its authority under subdivision (c) of Section 100504 of the
4 Government Code. Nothing in this subdivision shall require an
5 insurer that does not participate in the Exchange to offer
6 standardized products in the small employer market if the insurer
7 only sells products in the individual market. Nothing in this
8 subdivision shall require an insurer that does not participate in the
9 Exchange to offer standardized products in the individual market
10 if the insurer only sells products in the small employer market.
11 This subdivision shall not be construed to prohibit the insurer from
12 offering other products provided that it complies with subdivision
13 (d).

14 (f) This section shall become operative only if Section 11 of the
15 act that added this section becomes inoperative pursuant to
16 subdivision (g) of that Section 11.

17 ~~SEC. 19.~~

18 *SEC. 18.* Section 10113.9 of the Insurance Code is amended
19 to read:

20 10113.9. (a) This section shall not apply to short-term limited
21 duration health insurance, vision-only, dental-only, or
22 CHAMPUS-supplement insurance, or to hospital indemnity,
23 hospital-only, accident-only, or specified disease insurance that
24 does not pay benefits on a fixed benefit, cash payment only basis.

25 (b) (1) No change in the premium rate or coverage for an
26 individual health insurance policy shall become effective unless
27 the insurer has delivered a written notice of the change at least 15
28 days prior to the start of the annual enrollment period applicable
29 to the policy or 60 days prior to the effective date of the policy
30 renewal, whichever occurs earlier in the calendar year.

31 (2) The written notice required pursuant to paragraph (1) shall
32 be delivered to the individual policyholder at his or her last address
33 known to the insurer. The notice shall state in italics and in 12-point
34 type the actual dollar amount of the premium increase and the
35 specific percentage by which the current premium will be
36 increased. The notice shall describe in plain, understandable
37 English any changes in the policy or any changes in benefits,
38 including a reduction in benefits or changes to waivers, exclusions,
39 or conditions, and highlight this information by printing it in italics.
40 The notice shall specify in a minimum of 10-point bold typeface,

1 the reason for a premium rate change or a change in coverage or
2 benefits.

3 (c) If an insurer rejects a dependent of a policyholder applying
4 to be added to the policyholder's individual grandfathered health
5 plan, rejects an applicant for a Medicare supplement policy due
6 to the applicant having end-stage renal disease, or offers an
7 individual grandfathered health plan to an applicant at a rate that
8 is higher than the standard rate, the insurer shall inform the
9 applicant about the California Major Risk Medical Insurance
10 Program (MRMIP) (Part 6.5 (commencing with Section 12700)
11 of Division 2) and about the new coverage options, and the
12 potential for subsidized coverage, through Covered California.
13 The insurer shall direct persons seeking more information to
14 MRMIP, Covered California, plan or policy representatives,
15 insurance agents, or an entity paid by Covered California to assist
16 with health coverage enrollment, such as a navigator or an assister.

17 (d) A notice provided pursuant to this section is a private and
18 confidential communication and, at the time of application, the
19 insurer shall give the applicant the opportunity to designate the
20 address for receipt of the written notice in order to protect the
21 confidentiality of any personal or privileged information.

22 (e) For purposes of this section, the following definitions shall
23 apply:

24 (1) "Covered California" means the California Health Benefit
25 Exchange established pursuant to Section 100500 of the
26 Government Code.

27 (2) "Grandfathered health plan" has the same meaning as that
28 term is defined in Section 1251 of PPACA.

29 (3) "PPACA" means the federal Patient Protection and
30 Affordable Care Act (Public Law 111-148), as amended by the
31 federal Health Care and Education Reconciliation Act of 2010
32 (Public Law 111-152), and any rules, regulations, or guidance
33 issued pursuant to that law.

34 ~~SEC. 20.~~

35 *SEC. 19.* Section 10181.3 of the Insurance Code is amended
36 to read:

37 10181.3. (a) All health insurers shall file with the department
38 all required rate information for individual and small group health
39 insurance policies at least 60 days prior to implementing any rate
40 change.

(b) An insurer shall disclose to the department all of the following for each individual and small group rate filing:

- (1) Company name and contact information.
- (2) Number of policy forms covered by the filing.
- (3) Policy form numbers covered by the filing.
- (4) Product type, such as indemnity or preferred provider organization.
- (5) Segment type.
- (6) Type of insurer involved, such as for profit or not for profit.
- (7) Whether the products are opened or closed.
- (8) Enrollment in each policy and rating form.
- (9) Insured months in each policy form.
- (10) Annual rate.
- (11) Total earned premiums in each policy form.
- (12) Total incurred claims in each policy form.
- (13) Average rate ~~change~~ *increase* initially requested.
- (14) Review category: initial filing for new product, filing for existing product, or resubmission.
- (15) Average rate of ~~change~~ *increase*.
- (16) Effective date of rate ~~change~~ *increase*.
- (17) Number of policyholders or insureds affected by each policy form.
- (18) The insurer's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. An insurer may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost ~~changes~~ *increases* in specific benefit categories in the geographic regions listed in Sections 10753.14 and 10965.9. For purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions.
- (19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.
- (20) A comparison of claims cost and rate of changes over time.

- 1 (21) Any changes in insured cost sharing over the prior year
2 associated with the submitted rate filing.
- 3 (22) Any changes in insured benefits over the prior year
4 associated with the submitted rate filing.
- 5 (23) The certification described in subdivision (b) of Section
6 10181.6.
- 7 (24) Any changes in administrative costs.
- 8 (25) Any other information required for rate review under
9 PPACA.
- 10 (c) An insurer subject to subdivision (a) shall also disclose the
11 following aggregate data for all rate filings submitted under this
12 section in the individual and small group health insurance markets:
- 13 (1) Number and percentage of rate filings reviewed by the
14 following:
- 15 (A) Plan year.
16 (B) Segment type.
17 (C) Product type.
18 (D) Number of policyholders.
19 (E) Number of covered lives affected.
- 20 (2) The insurer's average rate ~~change~~ *increase* by the following
21 categories:
- 22 (A) Plan year.
23 (B) Segment type.
24 (C) Product type.
- 25 (3) Any cost containment and quality improvement efforts since
26 the insurer's last rate filing for the same category of health benefit
27 plan. To the extent possible, the insurer shall describe any
28 significant new health care cost containment and quality
29 improvement efforts and provide an estimate of potential savings
30 together with an estimated cost or savings for the projection period.
- 31 (d) The department may require all health insurers to submit all
32 rate filings to the National Association of Insurance
33 Commissioners' System for Electronic Rate and Form Filing
34 (SERFF). Submission of the required rate filings to SERFF shall
35 be deemed to be filing with the department for purposes of
36 compliance with this section.
- 37 (e) A health insurer shall submit any other information required
38 under PPACA. A health insurer shall also submit any other
39 information required pursuant to any regulation adopted by the
40 department to comply with this article.

1 ~~SEC. 21. Section 10181.6 of the Insurance Code is amended to~~
2 ~~read:~~

3 ~~10181.6. (a) A filing submitted under this article shall be~~
4 ~~actuarially sound.~~

5 ~~(b) (1) The health insurer shall contract with an independent~~
6 ~~actuary or actuaries consistent with this section.~~

7 ~~(2) A filing submitted under this article shall include a~~
8 ~~certification by an independent actuary or actuarial firm that the~~
9 ~~rate change is reasonable or unreasonable and, if unreasonable,~~
10 ~~that the justification for the change is based on accurate and sound~~
11 ~~actuarial assumptions and methodologies. Unless PPACA requires~~
12 ~~a certification of actuarial soundness for each large group health~~
13 ~~insurance policy, a filing submitted under Section 10181.4 shall~~
14 ~~include a certification by an independent actuary, as described in~~
15 ~~this section, that the aggregate or average rate increase is based~~
16 ~~on accurate and sound actuarial assumptions and methodologies.~~

17 ~~(3) The actuary or actuarial firm acting under paragraph (2)~~
18 ~~shall not be an affiliate or a subsidiary of, nor in any way owned~~
19 ~~or controlled by, a health insurer or a trade association of health~~
20 ~~insurers. A board member, director, officer, or employee of the~~
21 ~~actuary or actuarial firm shall not serve as a board member,~~
22 ~~director, or employee of a health insurer. A board member, director,~~
23 ~~or officer of a health insurer or a trade association of health insurers~~
24 ~~shall not serve as a board member, director, officer, or employee~~
25 ~~of the actuary or actuarial firm.~~

26 ~~(c) Nothing in this article shall be construed to permit the~~
27 ~~commissioner to establish the rates charged insureds and~~
28 ~~policyholders for covered health care services.~~

29 ~~SEC. 22. Section 10181.7 of the Insurance Code is amended~~
30 ~~to read:~~

31 ~~10181.7. (a) Notwithstanding Chapter 3.5 (commencing with~~
32 ~~Section 6250) of Division 7 of Title 1 of the Government Code,~~
33 ~~all information submitted under this article shall be made publicly~~
34 ~~available by the department except as provided in subdivision (b).~~

35 ~~(b) Any contracted rates between a health insurer and a provider~~
36 ~~shall be deemed confidential information that shall not be made~~
37 ~~public by the department and are exempt from disclosure under~~
38 ~~the California Public Records Act (Chapter 3.5 (commencing with~~
39 ~~Section 6250) of Division 7 of Title 1 of the Government Code).~~

40 ~~The contracted rates between a health insurer and a large group~~

1 ~~shall be deemed confidential information that shall not be made~~
2 ~~public by the department and are exempt from disclosure under~~
3 ~~the California Public Records Act (Chapter 3.5 (commencing with~~
4 ~~Section 6250) of Division 7 of Title 1 of the Government Code).~~

5 (e) ~~All information submitted to the department under this article~~
6 ~~shall be submitted electronically in order to facilitate review by~~
7 ~~the department and the public.~~

8 (d) ~~In addition, the department and the health insurer shall, at~~
9 ~~a minimum, make the following information readily available to~~
10 ~~the public on their Internet Web sites, in plain language and in a~~
11 ~~manner and format specified by the department, except as provided~~
12 ~~in subdivision (b). The information shall be made public for 60~~
13 ~~days prior to the implementation of the rate change. The~~
14 ~~information shall include:~~

15 (1) ~~Justifications for any unreasonable rate changes, including~~
16 ~~all information and supporting documentation as to why the rate~~
17 ~~change is justified.~~

18 (2) ~~An insurer's overall annual medical trend factor assumptions~~
19 ~~in each rate filing for all benefits.~~

20 (3) ~~An insurer's actual costs, by aggregate benefit category to~~
21 ~~include, hospital inpatient, hospital outpatient, physician services,~~
22 ~~prescription drugs and other ancillary services, laboratory, and~~
23 ~~radiology.~~

24 (4) ~~The amount of the projected trend attributable to the use of~~
25 ~~services, price inflation, or fees and risk for annual policy trends~~
26 ~~by aggregate benefit category, such as hospital inpatient, hospital~~
27 ~~outpatient, physician services, prescription drugs and other~~
28 ~~ancillary services, laboratory, and radiology.~~

29 ~~SEC. 23.~~

30 ~~SEC. 20.~~ Section 10181.11 of the Insurance Code is amended
31 to read:

32 10181.11. (a) Whenever it appears to the department that any
33 person has engaged, or is about to engage, in any act or practice
34 constituting a violation of this article, including the filing of
35 inaccurate or unjustified rates or inaccurate or unjustified rate
36 information, the department may review rate filing to ensure
37 compliance with the law.

38 (b) The department may review other filings.

39 (c) The department shall accept and post to its Internet Web site
40 any public comment on a rate-change *increase* submitted to the

1 department during the 60-day period described in subdivision (d)
2 of Section 10181.7.

3 (d) The department shall report to the Legislature at least
4 quarterly on all unreasonable rate filings.

5 (e) The department shall post on its Internet Web site any
6 ~~modifications~~ *changes* submitted by the insurer to the proposed
7 ~~rate change, increase~~, including any documentation submitted by
8 the insurer supporting those ~~modifications~~. *changes*.

9 (f) If the commissioner makes a decision that an unreasonable
10 ~~rate change increase~~ is not justified or that a rate filing contains
11 inaccurate information, the department shall post that decision on
12 its Internet Web site.

13 (g) Nothing in this article shall be construed to impair or impede
14 the department's authority to administer or enforce any other
15 provision of this code.

16 ~~SEC. 24.~~

17 *SEC. 21.* Section 10199.1 of the Insurance Code is amended
18 to read:

19 10199.1. (a) No insurer or nonprofit hospital service plan or
20 administrator acting on its behalf shall terminate a group master
21 policy or contract providing hospital, medical, or surgical benefits,
22 increase premiums or charges therefor, reduce or eliminate benefits
23 thereunder, or restrict eligibility for coverage thereunder without
24 providing prior notice of that action. No such action shall become
25 effective unless written notice of the action was delivered by mail
26 to the last known address of the appropriate insurance producer
27 and the appropriate administrator, if any, at least 45 days prior to
28 the effective date of the action and to the last known address of
29 the group policyholder or group contractholder at least 60 days
30 prior to the effective date of the action. If nonemployee certificate
31 holders or employees of more than one employer are covered under
32 the policy or contract, written notice shall also be delivered by
33 mail to the last known address of each nonemployee certificate
34 holder or affected employer or, if the action does not affect all
35 employees and dependents of one or more employers, to the last
36 known address of each affected employee certificate holder, at
37 least 60 days prior to the effective date of the action.

38 (b) No holder of a master group policy or a master group
39 nonprofit hospital service plan contract or administrator acting on
40 its behalf shall terminate the coverage of, increase premiums or

1 charges for, or reduce or eliminate benefits available to, or restrict
2 eligibility for coverage of a covered person, employer unit, or class
3 of certificate holders covered under the policy or contract for
4 hospital, medical, or surgical benefits without first providing prior
5 notice of the action. No such action shall become effective unless
6 written notice was delivered by mail to the last known address of
7 each affected nonemployee certificate holder or employer, or if
8 the action does not affect all employees and dependents of one or
9 more employers, to the last known address of each affected
10 employee certificate holder, at least 60 days prior to the effective
11 date of the action.

12 (c) A health insurer that declines to offer coverage to or denies
13 enrollment for a large group applying for coverage shall, at the
14 time of the denial of coverage, provide the applicant with the
15 specific reason or reasons for the decision in writing, in clear,
16 easily understandable language.

17 ~~SEC. 25.~~

18 *SEC. 22.* Section 10753.05 of the Insurance Code is amended
19 to read:

20 10753.05. (a) No group or individual policy or contract or
21 certificate of group insurance or statement of group coverage
22 providing benefits to employees of small employers as defined in
23 this chapter shall be issued or delivered by a carrier subject to the
24 jurisdiction of the commissioner regardless of the situs of the
25 contract or master policyholder or of the domicile of the carrier
26 nor, except as otherwise provided in Sections 10270.91 and
27 10270.92, shall a carrier provide coverage subject to this chapter
28 until a copy of the form of the policy, contract, certificate, or
29 statement of coverage is filed with and approved by the
30 commissioner in accordance with Sections 10290 and 10291, and
31 the carrier has complied with the requirements of Section 10753.17.

32 (b) (1) On and after October 1, 2013, each carrier shall fairly
33 and affirmatively offer, market, and sell all of the carrier's health
34 benefit plans that are sold to, offered through, or sponsored by,
35 small employers or associations that include small employers for
36 plan years on or after January 1, 2014, to all small employers in
37 each geographic region in which the carrier makes coverage
38 available or provides benefits.

39 (2) A carrier that offers qualified health plans through the
40 Exchange shall be deemed to be in compliance with paragraph (1)

1 with respect to health benefit plans offered through the Exchange
2 in those geographic regions in which the carrier offers plans
3 through the Exchange.

4 (3) A carrier shall provide enrollment periods consistent with
5 PPACA and described in Section 155.725 of Title 45 of the Code
6 of Federal Regulations. Commencing January 1, 2014, a carrier
7 shall provide special enrollment periods consistent with the special
8 enrollment periods described in Section 10965.3, to the extent
9 permitted by PPACA, except for the triggering events identified
10 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
11 the Code of Federal Regulations with respect to health benefit
12 plans offered through the Exchange.

13 (4) Nothing in this section shall be construed to require an
14 association, or a trust established and maintained by an association
15 to receive a master insurance policy issued by an admitted insurer
16 and to administer the benefits thereof solely for association
17 members, to offer, market, or sell a benefit plan design to those
18 who are not members of the association. However, if the
19 association markets, offers, or sells a benefit plan design to those
20 who are not members of the association it is subject to the
21 requirements of this section. This shall apply to an association that
22 otherwise meets the requirements of paragraph (8) formed by
23 merger of two or more associations after January 1, 1992, if the
24 predecessor organizations had been in active existence on January
25 1, 1992, and for at least five years prior to that date and met the
26 requirements of paragraph (5).

27 (5) A carrier which (A) effective January 1, 1992, and at least
28 20 years prior to that date, markets, offers, or sells benefit plan
29 designs only to all members of one association and (B) does not
30 market, offer, or sell any other individual, selected group, or group
31 policy or contract providing medical, hospital, and surgical benefits
32 shall not be required to market, offer, or sell to those who are not
33 members of the association. However, if the carrier markets, offers,
34 or sells any benefit plan design or any other individual, selected
35 group, or group policy or contract providing medical, hospital, and
36 surgical benefits to those who are not members of the association
37 it is subject to the requirements of this section.

38 (6) Each carrier that sells health benefit plans to members of
39 one association pursuant to paragraph (5) shall submit an annual
40 statement to the commissioner which states that the carrier is selling

1 health benefit plans pursuant to paragraph (5) and which, for the
2 one association, lists all the information required by paragraph (7).

3 (7) Each carrier that sells health benefit plans to members of
4 any association shall submit an annual statement to the
5 commissioner which lists each association to which the carrier
6 sells health benefit plans, the industry or profession which is served
7 by the association, the association's membership criteria, a list of
8 officers, the state in which the association is organized, and the
9 site of its principal office.

10 (8) For purposes of paragraphs (4) and (6), an association is a
11 nonprofit organization comprised of a group of individuals or
12 employers who associate based solely on participation in a
13 specified profession or industry, accepting for membership any
14 individual or small employer meeting its membership criteria,
15 which do not condition membership directly or indirectly on the
16 health or claims history of any person, which uses membership
17 dues solely for and in consideration of the membership and
18 membership benefits, except that the amount of the dues shall not
19 depend on whether the member applies for or purchases insurance
20 offered by the association, which is organized and maintained in
21 good faith for purposes unrelated to insurance, which has been in
22 active existence on January 1, 1992, and at least five years prior
23 to that date, which has a constitution and bylaws, or other
24 analogous governing documents which provide for election of the
25 governing board of the association by its members, which has
26 contracted with one or more carriers to offer one or more health
27 benefit plans to all individual members and small employer
28 members in this state. Health coverage through an association that
29 is not related to employment shall be considered individual
30 coverage pursuant to Section 144.102(c) of Title 45 of the Code
31 of Federal Regulations.

32 (c) On and after October 1, 2013, each carrier shall make
33 available to each small employer all health benefit plans that the
34 carrier offers or sells to small employers or to associations that
35 include small employers for plan years on or after January 1, 2014.
36 Notwithstanding subdivision (d) of Section 10753, for purposes
37 of this subdivision, companies that are affiliated companies or that
38 are eligible to file a consolidated income tax return shall be treated
39 as one carrier.

40 (d) Each carrier shall do all of the following:

1 (1) Prepare a brochure that summarizes all of its health benefit
2 plans and make this summary available to small employers, agents,
3 and brokers upon request. The summary shall include for each
4 plan information on benefits provided, a generic description of the
5 manner in which services are provided, such as how access to
6 providers is limited, benefit limitations, required copayments and
7 deductibles, an explanation of how creditable coverage is calculated
8 if a waiting period is imposed, and a telephone number that can
9 be called for more detailed benefit information. Carriers are
10 required to keep the information contained in the brochure accurate
11 and up to date, and, upon updating the brochure, send copies to
12 agents and brokers representing the carrier. Any entity that provides
13 administrative services only with regard to a health benefit plan
14 written or issued by another carrier shall not be required to prepare
15 a summary brochure which includes that benefit plan.

16 (2) For each health benefit plan, prepare a more detailed
17 evidence of coverage and make it available to small employers,
18 agents, and brokers upon request. The evidence of coverage shall
19 contain all information that a prudent buyer would need to be aware
20 of in making selections of benefit plan designs. An entity that
21 provides administrative services only with regard to a health benefit
22 plan written or issued by another carrier shall not be required to
23 prepare an evidence of coverage for that health benefit plan.

24 (3) Provide copies of the current summary brochure to all agents
25 or brokers who represent the carrier and, upon updating the
26 brochure, send copies of the updated brochure to agents and brokers
27 representing the carrier for the purpose of selling health benefit
28 plans.

29 (4) Notwithstanding subdivision (c) of Section 10753, for
30 purposes of this subdivision, companies that are affiliated
31 companies or that are eligible to file a consolidated income tax
32 return shall be treated as one carrier.

33 (e) Every agent or broker representing one or more carriers for
34 the purpose of selling health benefit plans to small employers shall
35 do all of the following:

36 (1) When providing information on a health benefit plan to a
37 small employer but making no specific recommendations on
38 particular benefit plan designs:

39 (A) Advise the small employer of the carrier's obligation to sell
40 to any small employer any of the health benefit plans it offers to

1 small employers, consistent with PPACA, and provide them, upon
2 request, with the actual rates that would be charged to that
3 employer for a given health benefit plan.

4 (B) Notify the small employer that the agent or broker will
5 procure rate and benefit information for the small employer on
6 any health benefit plan offered by a carrier for whom the agent or
7 broker sells health benefit plans.

8 (C) Notify the small employer that, upon request, the agent or
9 broker will provide the small employer with the summary brochure
10 required in paragraph (1) of subdivision (d) for any benefit plan
11 design offered by a carrier whom the agent or broker represents.

12 (D) Notify the small employer of the availability of coverage
13 and the availability of tax credits for certain employers consistent
14 with PPACA and state law, including any rules, regulations, or
15 guidance issued in connection therewith.

16 (2) When recommending a particular benefit plan design or
17 designs, advise the small employer that, upon request, the agent
18 will provide the small employer with the brochure required by
19 paragraph (1) of subdivision (d) containing the benefit plan design
20 or designs being recommended by the agent or broker.

21 (3) Prior to filing an application for a small employer for a
22 particular health benefit plan:

23 (A) For each of the health benefit plans offered by the carrier
24 whose health benefit plan the agent or broker is presenting, provide
25 the small employer with the benefit summary required in paragraph
26 (1) of subdivision (d) and the premium for that particular employer.

27 (B) Notify the small employer that, upon request, the agent or
28 broker will provide the small employer with an evidence of
29 coverage brochure for each health benefit plan the carrier offers.

30 (C) Obtain a signed statement from the small employer
31 acknowledging that the small employer has received the disclosures
32 required by this paragraph and Section 10753.16.

33 (f) No carrier, agent, or broker shall induce or otherwise
34 encourage a small employer to separate or otherwise exclude an
35 eligible employee from a health benefit plan which, in the case of
36 an eligible employee meeting the definition in paragraph (1) of
37 subdivision (f) of Section 10753, is provided in connection with
38 the employee's employment or which, in the case of an eligible
39 employee as defined in paragraph (2) of subdivision (f) of Section
40 10753, is provided in connection with a guaranteed association.

1 (g) No carrier shall reject an application from a small employer
2 for a health benefit plan provided:

3 (1) The small employer as defined by subparagraph (A) of
4 paragraph (1) of subdivision (q) of Section 10753 offers health
5 benefits to 100 percent of its eligible employees as defined in
6 paragraph (1) of subdivision (f) of Section 10753. Employees who
7 waive coverage on the grounds that they have other group coverage
8 shall not be counted as eligible employees.

9 (2) The small employer agrees to make the required premium
10 payments.

11 (h) No carrier or agent or broker shall, directly or indirectly,
12 engage in the following activities:

13 (1) Encourage or direct small employers to refrain from filing
14 an application for coverage with a carrier because of the health
15 status, claims experience, industry, occupation, or geographic
16 location within the carrier's approved service area of the small
17 employer or the small employer's employees.

18 (2) Encourage or direct small employers to seek coverage from
19 another carrier because of the health status, claims experience,
20 industry, occupation, or geographic location within the carrier's
21 approved service area of the small employer or the small
22 employer's employees.

23 (3) Employ marketing practices or benefit designs that will have
24 the effect of discouraging the enrollment of individuals with
25 significant health needs or discriminate based on the individual's
26 race, color, national origin, present or predicted disability, age,
27 sex, gender identity, sexual orientation, expected length of life,
28 degree of medical dependency, quality of life, or other health
29 conditions.

30 This subdivision shall be enforced in the same manner as Section
31 790.03, including through Sections 790.035 and 790.05.

32 (i) No carrier shall, directly or indirectly, enter into any contract,
33 agreement, or arrangement with an agent or broker that provides
34 for or results in the compensation paid to an agent or broker for a
35 health benefit plan to be varied because of the health status, claims
36 experience, industry, occupation, or geographic location of the
37 small employer or the small employer's employees. This
38 subdivision shall not apply with respect to a compensation
39 arrangement that provides compensation to an agent or broker on
40 the basis of percentage of premium, provided that the percentage

1 shall not vary because of the health status, claims experience,
2 industry, occupation, or geographic area of the small employer.

3 (j) (1) A health benefit plan offered to a small employer, as
4 defined in Section 1304(b) of PPACA and in Section 10753, shall
5 not establish rules for eligibility, including continued eligibility,
6 of an individual, or dependent of an individual, to enroll under the
7 terms of the plan based on any of the following health status-related
8 factors:

9 (A) Health status.

10 (B) Medical condition, including physical and mental illnesses.

11 (C) Claims experience.

12 (D) Receipt of health care.

13 (E) Medical history.

14 (F) Genetic information.

15 (G) Evidence of insurability, including conditions arising out
16 of acts of domestic violence.

17 (H) Disability.

18 (I) Any other health status-related factor as determined by any
19 federal regulations, rules, or guidance issued pursuant to Section
20 2705 of the federal Public Health Service Act.

21 (2) Notwithstanding Section 10291.5, a carrier shall not require
22 an eligible employee or dependent to fill out a health assessment
23 or medical questionnaire prior to enrollment under a health benefit
24 plan. A carrier shall not acquire or request information that relates
25 to a health status-related factor from the applicant or his or her
26 dependent or any other source prior to enrollment of the individual.

27 (k) (1) A carrier shall consider as a single risk pool for rating
28 purposes in the small employer market the claims experience of
29 all insureds in all nongrandfathered small employer health benefit
30 plans offered by the carrier in this state, whether offered as health
31 care service plan contracts or health insurance policies, including
32 those insureds and enrollees who enroll in coverage through the
33 Exchange and insureds and enrollees covered by the carrier outside
34 of the Exchange.

35 (2) At least each calendar year, and no more frequently than
36 each calendar quarter, a carrier shall establish an index rate for the
37 small employer market in the state based on the total combined
38 claims costs for providing essential health benefits, as defined
39 pursuant to Section 1302 of PPACA and Section 10112.27, within
40 the single risk pool required under paragraph (1). The index rate

1 shall be adjusted on a marketwide basis based on the total expected
2 marketwide payments and charges under the risk adjustment and
3 reinsurance programs established for the state pursuant to Sections
4 1343 and 1341 of PPACA and Exchange user fees, as described
5 in subdivision (d) of Section 156.80 of Title 45 of the Code of
6 Federal Regulations. The premium rate for all of the
7 nongrandfathered health benefit plans within the single risk pool
8 required under paragraph (1) shall use the applicable marketwide
9 adjusted index rate, subject only to the adjustments permitted under
10 paragraph (3).

11 (3) A carrier may vary premium rates for a particular
12 nongrandfathered health benefit plan from its index rate based
13 only on the following actuarially justified plan-specific factors:

14 (A) The actuarial value and cost-sharing design of the health
15 benefit plan.

16 (B) The health benefit plan's provider network, delivery system
17 characteristics, and utilization management practices.

18 (C) The benefits provided under the health benefit plan that are
19 in addition to the essential health benefits, as defined pursuant to
20 Section 1302 of PPACA. These additional benefits shall be pooled
21 with similar benefits within the single risk pool required under
22 paragraph (1) and the claims experience from those benefits shall
23 be utilized to determine rate variations for health benefit plans that
24 offer those benefits in addition to essential health benefits.

25 (D) Administrative costs, excluding any user fees required by
26 the Exchange.

27 (E) With respect to catastrophic plans, as described in subsection
28 (e) of Section 1302 of PPACA, the expected impact of the specific
29 eligibility categories for those plans.

30 (f) If a carrier enters into a contract, agreement, or other
31 arrangement with a third-party administrator or other entity to
32 provide administrative, marketing, or other services related to the
33 offering of health benefit plans to small employers in this state,
34 the third-party administrator shall be subject to this chapter.

35 (m) (1) Except as provided in paragraph (2), this section shall
36 become inoperative if Section 2702 of the federal Public Health
37 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
38 of PPACA, is repealed, in which case, 12 months after the repeal,
39 carriers subject to this section shall instead be governed by Section
40 10705 to the extent permitted by federal law, and all references in

1 this chapter to this section shall instead refer to Section 10705,
2 except for purposes of paragraph (2).

3 (2) Paragraph (3) of subdivision (b) of this section shall remain
4 operative as it relates to health benefit plans offered through the
5 Exchange.

6 ~~SEC. 26. Section 10965.3 of the Insurance Code is amended~~
7 ~~to read:~~

8 ~~10965.3. (a) (1) On and after October 1, 2013, a health insurer~~
9 ~~shall fairly and affirmatively offer, market, and sell all of the~~
10 ~~insurer's health benefit plans that are sold in the individual market~~
11 ~~for policy years on or after January 1, 2014, to all individuals and~~
12 ~~dependents in each service area in which the insurer provides or~~
13 ~~arranges for the provision of health care services. A health insurer~~
14 ~~shall limit enrollment in individual health benefit plans to open~~
15 ~~enrollment periods and special enrollment periods as provided in~~
16 ~~subdivisions (c) and (d).~~

17 ~~(2) A health insurer shall allow the policyholder of an individual~~
18 ~~health benefit plan to add a dependent to the policyholder's health~~
19 ~~benefit plan at the option of the policyholder, consistent with the~~
20 ~~open enrollment, annual enrollment, and special enrollment period~~
21 ~~requirements in this section.~~

22 ~~(b) An individual health benefit plan issued, amended, or~~
23 ~~renewed on or after January 1, 2014, shall not impose any~~
24 ~~preexisting condition provision upon any individual.~~

25 ~~(c) (1) A health insurer shall provide an initial open enrollment~~
26 ~~period from October 1, 2013, to March 31, 2014, inclusive, and~~
27 ~~annual enrollment periods for plan years on or after January 1,~~
28 ~~2015, from October 15 to December 7, inclusive, of the preceding~~
29 ~~calendar year.~~

30 ~~(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code~~
31 ~~of Federal Regulations, for individuals enrolled in noncalendar-year~~
32 ~~individual health plan contracts, a plan shall provide a limited open~~
33 ~~enrollment period beginning on the date that is 30 calendar days~~
34 ~~prior to the date the policy year ends in 2014.~~

35 ~~(d) (1) Subject to paragraph (2), commencing January 1, 2014,~~
36 ~~a health insurer shall allow an individual to enroll in or change~~
37 ~~individual health benefit plans as a result of the following triggering~~
38 ~~events:~~

1 (A) He or she or his or her dependent loses minimum essential
2 coverage. For purposes of this paragraph, the following definitions
3 shall apply:

4 (i) “Minimum essential coverage” has the same meaning as that
5 term is defined in subsection (f) of Section 5000A of the Internal
6 Revenue Code (26 U.S.C. Sec. 5000A).

7 (ii) “Loss of minimum essential coverage” includes, but is not
8 limited to, loss of that coverage due to the circumstances described
9 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
10 Code of Federal Regulations and the circumstances described in
11 Section 1163 of Title 29 of the United States Code. “Loss of
12 minimum essential coverage” also includes loss of that coverage
13 for a reason that is not due to the fault of the individual.

14 (iii) “Loss of minimum essential coverage” does not include
15 loss of that coverage due to the individual’s failure to pay
16 premiums on a timely basis or situations allowing for a rescission,
17 subject to clause (ii) and Sections 10119.2 and 10384.17.

18 (B) He or she gains a dependent or becomes a dependent.

19 (C) He or she is mandated to be covered as a dependent pursuant
20 to a valid state or federal court order.

21 (D) He or she has been released from incarceration.

22 (E) His or her health coverage issuer substantially violated a
23 material provision of the health coverage contract.

24 (F) He or she gains access to new health benefit plans as a result
25 of a permanent move.

26 (G) He or she was receiving services from a contracting provider
27 under another health benefit plan, as defined in Section 10965 of
28 this code or Section 1399.845 of the Health and Safety Code for
29 one of the conditions described in subdivision (a) of
30 Section 10133.56 and that provider is no longer participating in the
31 health benefit plan.

32 (H) He or she demonstrates to the Exchange, with respect to
33 health benefit plans offered through the Exchange, or to the
34 department, with respect to health benefit plans offered outside
35 the Exchange, that he or she did not enroll in a health benefit plan
36 during the immediately preceding enrollment period available to
37 the individual because he or she was misinformed that he or she
38 was covered under minimum essential coverage.

39 (I) He or she is a member of the reserve forces of the United
40 States military returning from active duty or a member of the

1 California National Guard returning from active duty service under
2 Title 32 of the United States Code.

3 ~~(J) With respect to individual health benefit plans offered~~
4 ~~through the Exchange, in addition to the triggering events listed~~
5 ~~in this paragraph, any other events listed in Section 155.420(d) of~~
6 ~~Title 45 of the Code of Federal Regulations.~~

7 ~~(2) With respect to individual health benefit plans offered~~
8 ~~outside the Exchange, an individual shall have 60 days from the~~
9 ~~date of a triggering event identified in paragraph (1) to apply for~~
10 ~~coverage from a health care service plan subject to this section.~~
11 ~~With respect to individual health benefit plans offered through the~~
12 ~~Exchange, an individual shall have 60 days from the date of a~~
13 ~~triggering event identified in paragraph (1) to select a plan offered~~
14 ~~through the Exchange, unless a longer period is provided in Part~~
15 ~~155 (commencing with Section 155.10) of Subchapter B of Subtitle~~
16 ~~A of Title 45 of the Code of Federal Regulations.~~

17 ~~(e) With respect to individual health benefit plans offered~~
18 ~~through the Exchange, the effective date of coverage required~~
19 ~~pursuant to this section shall be consistent with the dates specified~~
20 ~~in Section 155.410 or 155.420 of Title 45 of the Code of Federal~~
21 ~~Regulations, as applicable. A dependent who is a registered~~
22 ~~domestic partner pursuant to Section 297 of the Family Code shall~~
23 ~~have the same effective date of coverage as a spouse.~~

24 ~~(f) With respect to an individual health benefit plan offered~~
25 ~~outside the Exchange, the following provisions shall apply:~~

26 ~~(1) After an individual submits a completed application form~~
27 ~~for a plan, the insurer shall, within 30 days, notify the individual~~
28 ~~of the individual's actual premium charges for that plan established~~
29 ~~in accordance with Section 10965.9. The individual shall have 30~~
30 ~~days in which to exercise the right to buy coverage at the quoted~~
31 ~~premium charges.~~

32 ~~(2) With respect to an individual health benefit plan for which~~
33 ~~an individual applies during the initial open enrollment period~~
34 ~~described in subdivision (e), when the policyholder submits a~~
35 ~~premium payment, based on the quoted premium charges, and that~~
36 ~~payment is delivered or postmarked, whichever occurs earlier, by~~
37 ~~December 15, 2013, coverage under the individual health benefit~~
38 ~~plan shall become effective no later than January 1, 2014. When~~
39 ~~that payment is delivered or postmarked within the first 15 days~~
40 ~~of any subsequent month, coverage shall become effective no later~~

1 than the first day of the following month. When that payment is
2 delivered or postmarked between December 16, 2013, and
3 December 31, 2013, inclusive, or after the 15th day of any
4 subsequent month, coverage shall become effective no later than
5 the first day of the second month following delivery or postmark
6 of the payment.

7 (3) ~~With respect to an individual health benefit plan for which~~
8 ~~an individual applies during the annual open enrollment period~~
9 ~~described in subdivision (c), when the individual submits a~~
10 ~~premium payment, based on the quoted premium charges, and that~~
11 ~~payment is delivered or postmarked, whichever occurs later, by~~
12 ~~December 15, coverage shall become effective as of the following~~
13 ~~January 1. When that payment is delivered or postmarked within~~
14 ~~the first 15 days of any subsequent month, coverage shall become~~
15 ~~effective no later than the first day of the following month. When~~
16 ~~that payment is delivered or postmarked between December 16~~
17 ~~and December 31, inclusive, or after the 15th day of any subsequent~~
18 ~~month, coverage shall become effective no later than the first day~~
19 ~~of the second month following delivery or postmark of the~~
20 ~~payment.~~

21 (4) ~~With respect to an individual health benefit plan for which~~
22 ~~an individual applies during a special enrollment period described~~
23 ~~in subdivision (d), the following provisions shall apply:~~

24 (A) ~~When the individual submits a premium payment, based~~
25 ~~on the quoted premium charges, and that payment is delivered or~~
26 ~~postmarked, whichever occurs earlier, within the first 15 days of~~
27 ~~the month, coverage under the plan shall become effective no later~~
28 ~~than the first day of the following month. When the premium~~
29 ~~payment is neither delivered nor postmarked until after the 15th~~
30 ~~day of the month, coverage shall become effective no later than~~
31 ~~the first day of the second month following delivery or postmark~~
32 ~~of the payment.~~

33 (B) ~~Notwithstanding subparagraph (A), in the case of a birth,~~
34 ~~adoption, or placement for adoption, the coverage shall be effective~~
35 ~~on the date of birth, adoption, or placement for adoption.~~

36 (C) ~~Notwithstanding subparagraph (A), in the case of marriage~~
37 ~~or becoming a registered domestic partner or in the case where a~~
38 ~~qualified individual loses minimum essential coverage, the~~
39 ~~coverage effective date shall be the first day of the month following~~
40 ~~the date the insurer receives the request for special enrollment.~~

~~(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:~~

- ~~(A) Health status.~~
- ~~(B) Medical condition, including physical and mental illnesses.~~
- ~~(C) Claims experience.~~
- ~~(D) Receipt of health care.~~
- ~~(E) Medical history.~~
- ~~(F) Genetic information.~~
- ~~(G) Evidence of insurability, including conditions arising out of acts of domestic violence.~~
- ~~(H) Disability.~~
- ~~(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.~~

~~(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health insurer shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.~~

~~(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.~~

~~(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted~~

1 on a marketwide basis based on the total expected marketwide
2 payments and charges under the risk adjustment and reinsurance
3 programs established for the state pursuant to Sections 1343 and
4 1341 of PPACA and Exchange user fees, as described in
5 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal
6 Regulations. The premium rate for all of the health benefit plans
7 in the individual market within the single risk pool required under
8 paragraph (1) shall use the applicable marketwide adjusted index
9 rate, subject only to the adjustments permitted under paragraph
10 (3).

11 (3) A health insurer may vary premium rates for a particular
12 health benefit plan from its index rate based only on the following
13 actuarially justified plan-specific factors:

14 (A) The actuarial value and cost-sharing design of the health
15 benefit plan.

16 (B) The health benefit plan's provider network, delivery system
17 characteristics, and utilization management practices.

18 (C) The benefits provided under the health benefit plan that are
19 in addition to the essential health benefits, as defined pursuant
20 to Section 1302 of PPACA and Section 10112.27. These additional
21 benefits shall be pooled with similar benefits within the single risk
22 pool required under paragraph (1) and the claims experience from
23 those benefits shall be utilized to determine rate variations for
24 plans that offer those benefits in addition to essential health
25 benefits.

26 (D) With respect to catastrophic plans, as described in subsection
27 (e) of Section 1302 of PPACA, the expected impact of the specific
28 eligibility categories for those plans.

29 (E) Administrative costs, excluding any user fees required by
30 the Exchange.

31 (i) This section shall only apply with respect to individual health
32 benefit plans for policy years on or after January 1, 2014.

33 (j) This section shall not apply to a grandfathered health plan.

34 (k) If Section 5000A of the Internal Revenue Code, as added
35 by Section 1501 of PPACA, is repealed or amended to no longer
36 apply to the individual market, as defined in Section 2791 of the
37 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91);
38 subdivisions (a), (b), and (g) shall become inoperative 12 months
39 after the date of that repeal or amendment and individual health

1 ~~care benefit plans shall thereafter be subject to Sections 10901.2,~~
2 ~~10951, and 10953.~~

3 *SEC. 22.5. Section 10753.05 of the Insurance Code is amended*
4 *to read:*

5 10753.05. (a) No group or individual policy or contract or
6 certificate of group insurance or statement of group coverage
7 providing benefits to employees of small employers as defined in
8 this chapter shall be issued or delivered by a carrier subject to the
9 jurisdiction of the commissioner regardless of the situs of the
10 contract or master policyholder or of the domicile of the carrier
11 nor, except as otherwise provided in Sections 10270.91 and
12 10270.92, shall a carrier provide coverage subject to this chapter
13 until a copy of the form of the policy, contract, certificate, or
14 statement of coverage is filed with and approved by the
15 commissioner in accordance with Sections 10290 and 10291, and
16 the carrier has complied with the requirements of Section 10753.17.

17 (b) (1) On and after October 1, 2013, each carrier shall fairly
18 and affirmatively offer, market, and sell all of the carrier's health
19 benefit plans that are sold to, offered through, or sponsored by,
20 small employers or associations that include small employers for
21 plan years on or after January 1, 2014, to all small employers in
22 each geographic region in which the carrier makes coverage
23 available or provides benefits.

24 (2) A carrier that offers qualified health plans through the
25 Exchange shall be deemed to be in compliance with paragraph (1)
26 with respect to health benefit plans offered through the Exchange
27 in those geographic regions in which the carrier offers plans
28 through the Exchange.

29 (3) A carrier shall provide enrollment periods consistent with
30 PPACA and described in Section 155.725 of Title 45 of the Code
31 of Federal Regulations. Commencing January 1, 2014, a carrier
32 shall provide special enrollment periods consistent with the special
33 enrollment periods described in Section 10965.3, to the extent
34 permitted by PPACA, except for the triggering events identified
35 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
36 the Code of Federal Regulations with respect to health benefit
37 plans offered through the Exchange.

38 (4) Nothing in this section shall be construed to require an
39 association, or a trust established and maintained by an association
40 to receive a master insurance policy issued by an admitted insurer

1 and to administer the benefits thereof solely for association
2 members, to offer, ~~market~~ *market*, or sell a benefit plan design to
3 those who are not members of the association. However, if the
4 association markets, ~~offers~~ *offers*, or sells a benefit plan design to
5 those who are not members of the association it is subject to the
6 requirements of this section. This shall apply to an association that
7 otherwise meets the requirements of paragraph (8) formed by
8 merger of two or more associations after January 1, 1992, if the
9 predecessor organizations had been in active existence on January
10 1, 1992, and for at least five years prior to that date and met the
11 requirements of paragraph (5).

12 (5) A carrier which (A) effective January 1, 1992, and at least
13 20 years prior to that date, markets, offers, or sells benefit plan
14 designs only to all members of one association and (B) does not
15 market, ~~offer~~ *offer*, or sell any other individual, selected group, or
16 group policy or contract providing medical, ~~hospital~~ *hospital*, and
17 surgical benefits shall not be required to market, offer, or sell to
18 those who are not members of the association. However, if the
19 carrier markets, ~~offers~~ *offers*, or sells any benefit plan design or
20 any other individual, selected group, or group policy or contract
21 providing medical, ~~hospital~~ *hospital*, and surgical benefits to those
22 who are not members of the association it is subject to the
23 requirements of this section.

24 (6) Each carrier that sells health benefit plans to members of
25 one association pursuant to paragraph (5) shall submit an annual
26 statement to the commissioner which states that the carrier is selling
27 health benefit plans pursuant to paragraph (5) and which, for the
28 one association, lists all the information required by paragraph (7).

29 (7) Each carrier that sells health benefit plans to members of
30 any association shall submit an annual statement to the
31 commissioner which lists each association to which the carrier
32 sells health benefit plans, the industry or profession which is served
33 by the association, the association's membership criteria, a list of
34 officers, the state in which the association is organized, and the
35 site of its principal office.

36 (8) For purposes of paragraphs (4) and (6), an association is a
37 nonprofit organization comprised of a group of individuals or
38 employers who associate based solely on participation in a
39 specified profession or industry, accepting for membership any
40 individual or small employer meeting its membership criteria,

1 which do not condition membership directly or indirectly on the
2 health or claims history of any person, which uses membership
3 dues solely for and in consideration of the membership and
4 membership benefits, except that the amount of the dues shall not
5 depend on whether the member applies for or purchases insurance
6 offered by the association, which is organized and maintained in
7 good faith for purposes unrelated to insurance, which has been in
8 active existence on January 1, 1992, and at least five years prior
9 to that date, which has a constitution and bylaws, or other
10 analogous governing documents which provide for election of the
11 governing board of the association by its members, which has
12 contracted with one or more carriers to offer one or more health
13 benefit plans to all individual members and small employer
14 members in this state. Health coverage through an association that
15 is not related to employment shall be considered individual
16 coverage pursuant to Section 144.102(c) of Title 45 of the Code
17 of Federal Regulations.

18 (c) On and after October 1, 2013, each carrier shall make
19 available to each small employer all health benefit plans that the
20 carrier offers or sells to small employers or to associations that
21 include small employers for plan years on or after January 1, 2014.
22 Notwithstanding subdivision ~~(d)~~ (c) of Section 10753, for purposes
23 of this subdivision, companies that are affiliated companies or that
24 are eligible to file a consolidated income tax return shall be treated
25 as one carrier.

26 (d) Each carrier shall do all of the following:

27 (1) Prepare a brochure that summarizes all of its health benefit
28 plans and make this summary available to small employers, agents,
29 and brokers upon request. The summary shall include for each
30 plan information on benefits provided, a generic description of the
31 manner in which services are provided, such as how access to
32 providers is limited, benefit limitations, required copayments and
33 deductibles, ~~an explanation of how creditable coverage is calculated~~
34 ~~if a waiting period is imposed~~, and a telephone number that can
35 be called for more detailed benefit information. Carriers are
36 required to keep the information contained in the brochure accurate
37 and up to date, and, upon updating the brochure, send copies to
38 agents and brokers representing the carrier. Any entity that provides
39 administrative services only with regard to a health benefit plan

1 written or issued by another carrier shall not be required to prepare
2 a summary brochure which includes that benefit plan.

3 (2) For each health benefit plan, prepare a more detailed
4 evidence of coverage and make it available to small employers,
5 ~~agents~~ *agents*, and brokers upon request. The evidence of coverage
6 shall contain all information that a prudent buyer would need to
7 be aware of in making selections of benefit plan designs. An entity
8 that provides administrative services only with regard to a health
9 benefit plan written or issued by another carrier shall not be
10 required to prepare an evidence of coverage for that health benefit
11 plan.

12 (3) Provide copies of the current summary brochure to all agents
13 or brokers who represent the carrier and, upon updating the
14 brochure, send copies of the updated brochure to agents and brokers
15 representing the carrier for the purpose of selling health benefit
16 plans.

17 (4) Notwithstanding subdivision (c) of Section 10753, for
18 purposes of this subdivision, companies that are affiliated
19 companies or that are eligible to file a consolidated income tax
20 return shall be treated as one carrier.

21 (e) Every agent or broker representing one or more carriers for
22 the purpose of selling health benefit plans to small employers shall
23 do all of the following:

24 (1) When providing information on a health benefit plan to a
25 small employer but making no specific recommendations on
26 particular benefit plan designs:

27 (A) Advise the small employer of the carrier's obligation to sell
28 to any small employer any of the health benefit plans it offers to
29 small employers, consistent with PPACA, and provide them, upon
30 request, with the actual rates that would be charged to that
31 employer for a given health benefit plan.

32 (B) Notify the small employer that the agent or broker will
33 procure rate and benefit information for the small employer on
34 any health benefit plan offered by a carrier for whom the agent or
35 broker sells health benefit plans.

36 (C) Notify the small employer that, upon request, the agent or
37 broker will provide the small employer with the summary brochure
38 required in paragraph (1) of subdivision (d) for any benefit plan
39 design offered by a carrier whom the agent or broker represents.

1 (D) Notify the small employer of the availability of coverage
2 and the availability of tax credits for certain employers consistent
3 with PPACA and state law, including any rules, regulations, or
4 guidance issued in connection therewith.

5 (2) When recommending a particular benefit plan design or
6 designs, advise the small employer that, upon request, the agent
7 will provide the small employer with the brochure required by
8 paragraph (1) of subdivision (d) containing the benefit plan design
9 or designs being recommended by the agent or broker.

10 (3) Prior to filing an application for a small employer for a
11 particular health benefit plan:

12 (A) For each of the health benefit plans offered by the carrier
13 whose health benefit plan the agent or broker is presenting, provide
14 the small employer with the benefit summary required in paragraph
15 (1) of subdivision (d) and the premium for that particular employer.

16 (B) Notify the small employer that, upon request, the agent or
17 broker will provide the small employer with an evidence of
18 coverage brochure for each health benefit plan the carrier offers.

19 (C) Obtain a signed statement from the small employer
20 acknowledging that the small employer has received the disclosures
21 required by this paragraph and Section 10753.16.

22 (f) No carrier, agent, or broker shall induce or otherwise
23 encourage a small employer to separate or otherwise exclude an
24 eligible employee from a health benefit plan which, in the case of
25 an eligible employee meeting the definition in paragraph (1) of
26 subdivision (f) of Section 10753, is provided in connection with
27 the employee's employment or which, in the case of an eligible
28 employee as defined in paragraph (2) of subdivision (f) of Section
29 10753, is provided in connection with a guaranteed association.

30 (g) No carrier shall reject an application from a small employer
31 for a health benefit plan provided:

32 (1) The small employer as defined by subparagraph (A) of
33 paragraph (1) of subdivision (q) of Section 10753 offers health
34 benefits to 100 percent of its eligible employees as defined in
35 paragraph (1) of subdivision (f) of Section 10753. Employees who
36 waive coverage on the grounds that they have other group coverage
37 shall not be counted as eligible employees.

38 (2) The small employer agrees to make the required premium
39 payments.

1 (h) No carrier or agent or broker shall, directly or indirectly,
2 engage in the following activities:

3 (1) Encourage or direct small employers to refrain from filing
4 an application for coverage with a carrier because of the health
5 status, claims experience, industry, occupation, or geographic
6 location within the carrier's approved service area of the small
7 employer or the small employer's employees.

8 (2) Encourage or direct small employers to seek coverage from
9 another carrier because of the health status, claims experience,
10 industry, occupation, or geographic location within the carrier's
11 approved service area of the small employer or the small
12 employer's employees.

13 (3) Employ marketing practices or benefit designs that will have
14 the effect of discouraging the enrollment of individuals with
15 significant health needs or discriminate based on the individual's
16 race, color, national origin, present or predicted disability, age,
17 sex, gender identity, sexual orientation, expected length of life,
18 degree of medical dependency, quality of life, or other health
19 conditions.

20 This subdivision shall be enforced in the same manner as Section
21 790.03, including through Sections 790.035 and 790.05.

22 (i) No carrier shall, directly or indirectly, enter into any contract,
23 agreement, or arrangement with an agent or broker that provides
24 for or results in the compensation paid to an agent or broker for a
25 health benefit plan to be varied because of the health status, claims
26 experience, industry, occupation, or geographic location of the
27 small employer or the small employer's employees. This
28 subdivision shall not apply with respect to a compensation
29 arrangement that provides compensation to an agent or broker on
30 the basis of percentage of premium, provided that the percentage
31 shall not vary because of the health status, claims experience,
32 industry, occupation, or geographic area of the small employer.

33 (j) (1) A health benefit plan offered to a small employer, as
34 defined in Section 1304(b) of PPACA and in Section 10753, shall
35 not establish rules for eligibility, including continued eligibility,
36 of an individual, or dependent of an individual, to enroll under the
37 terms of the plan based on any of the following health status-related
38 factors:

39 (A) Health status.

40 (B) Medical condition, including physical and mental illnesses.

- 1 (C) Claims experience.
- 2 (D) Receipt of health care.
- 3 (E) Medical history.
- 4 (F) Genetic information.
- 5 (G) Evidence of insurability, including conditions arising out
- 6 of acts of domestic violence.
- 7 (H) Disability.
- 8 (I) Any other health status-related factor as determined by any
- 9 federal regulations, rules, or guidance issued pursuant to Section
- 10 2705 of the federal Public Health Service Act.

11 (2) Notwithstanding Section 10291.5, a carrier shall not require
12 an eligible employee or dependent to fill out a health assessment
13 or medical questionnaire prior to enrollment under a health benefit
14 plan. A carrier shall not acquire or request information that relates
15 to a health status-related factor from the applicant or his or her
16 dependent or any other source prior to enrollment of the individual.

17 (k) (1) A carrier shall consider as a single risk pool for rating
18 purposes in the small employer market the claims experience of
19 all insureds in all nongrandfathered small employer health benefit
20 plans offered by the carrier in this state, whether offered as health
21 care service plan contracts or health insurance policies, including
22 those insureds and enrollees who enroll in coverage through the
23 Exchange and insureds and enrollees covered by the carrier outside
24 of the Exchange.

25 (2) At least each calendar year, and no more frequently than
26 each calendar quarter, a carrier shall establish an index rate for the
27 small employer market in the state based on the total combined
28 claims costs for providing essential health benefits, as defined
29 pursuant to Section 1302 of PPACA and Section 10112.27, within
30 the single risk pool required under paragraph (1). The index rate
31 shall be adjusted on a marketwide basis based on the total expected
32 marketwide payments and charges under the risk adjustment and
33 reinsurance programs established for the state pursuant to Sections
34 1343 and 1341 of PPACA *and Exchange user fees, as described*
35 *in subdivision (d) of Section 156.80 of Title 45 of the Code of*
36 *Federal Regulations*. The premium rate for all of the ~~carrier's~~
37 ~~nongrandfathered health benefit plans shall use the applicable~~
38 ~~index rate, as adjusted for total expected marketwide payments~~
39 ~~and charges under the risk adjustment and reinsurance programs~~
40 ~~established for the state pursuant to Sections 1343 and 1341 of~~

1 ~~PPACA~~, within the single risk pool required under paragraph (1)
2 shall use the applicable marketwide adjusted index rate, subject
3 only to the adjustments permitted under paragraph (3).

4 (3) A carrier may vary premium rates for a particular
5 nongrandfathered health benefit plan from its index rate based
6 only on the following actuarially justified plan-specific factors:

7 (A) The actuarial value and cost-sharing design of the health
8 benefit plan.

9 (B) The health benefit plan's provider network, delivery system
10 characteristics, and utilization management practices.

11 (C) The benefits provided under the health benefit plan that are
12 in addition to the essential health benefits, as defined pursuant to
13 Section 1302 of PPACA. These additional benefits shall be pooled
14 with similar benefits within the single risk pool required under
15 paragraph (1) and the claims experience from those benefits shall
16 be utilized to determine rate variations for health benefit plans that
17 offer those benefits in addition to essential health benefits.

18 (D) Administrative costs, excluding any user fees required by
19 the Exchange.

20 (E) With respect to catastrophic plans, as described in subsection
21 (e) of Section 1302 of PPACA, the expected impact of the specific
22 eligibility categories for those plans.

23 (f) If a carrier enters into a contract, agreement, or other
24 arrangement with a third-party administrator or other entity to
25 provide administrative, marketing, or other services related to the
26 offering of health benefit plans to small employers in this state,
27 the third-party administrator shall be subject to this chapter.

28 (m) (1) Except as provided in paragraph (2), this section shall
29 become inoperative if Section 2702 of the federal Public Health
30 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
31 of PPACA, is repealed, in which case, 12 months after the repeal,
32 carriers subject to this section shall instead be governed by Section
33 10705 to the extent permitted by federal law, and all references in
34 this chapter to this section shall instead refer to Section 10705,
35 except for purposes of paragraph (2).

36 (2) Paragraph (3) of subdivision (b) of this section shall remain
37 operative as it relates to health benefit plans offered through the
38 Exchange.

39 SEC. 23. *Section 10965.3 of the Insurance Code is amended*
40 *to read:*

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder's health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2016, from October 15 to December 7, inclusive, of the preceding calendar year.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar-year individual health plan contracts, a health insurer shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

1 (ii) “Loss of minimum essential coverage” includes, but is not
2 limited to, loss of that coverage due to the circumstances described
3 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
4 Code of Federal Regulations and the circumstances described in
5 Section 1163 of Title 29 of the United States Code. “Loss of
6 minimum essential coverage” also includes loss of that coverage
7 for a reason that is not due to the fault of the individual.

8 (iii) “Loss of minimum essential coverage” does not include
9 loss of that coverage due to the individual’s failure to pay
10 premiums on a timely basis or situations allowing for a rescission,
11 subject to clause (ii) and Sections 10119.2 and 10384.17.

12 (B) He or she gains a dependent or becomes a dependent.

13 (C) He or she is mandated to be covered as a dependent pursuant
14 to a valid state or federal court order.

15 (D) He or she has been released from incarceration.

16 (E) His or her health coverage issuer substantially violated a
17 material provision of the health coverage contract.

18 (F) He or she gains access to new health benefit plans as a result
19 of a permanent move.

20 (G) He or she was receiving services from a contracting provider
21 under another health benefit plan, as defined in Section 10965 *of*
22 *this code* or Section 1399.845 of the Health and Safety Code, for
23 one of the conditions described in subdivision (a) of Section
24 10133.56 and that provider is no longer participating in the health
25 benefit plan.

26 (H) He or she demonstrates to the Exchange, with respect to
27 health benefit plans offered through the Exchange, or to the
28 department, with respect to health benefit plans offered outside
29 the Exchange, that he or she did not enroll in a health benefit plan
30 during the immediately preceding enrollment period available to
31 the individual because he or she was misinformed that he or she
32 was covered under minimum essential coverage.

33 (I) He or she is a member of the reserve forces of the United
34 States military returning from active duty or a member of the
35 California National Guard returning from active duty service under
36 Title 32 of the United States Code.

37 (J) With respect to individual health benefit plans offered
38 through the Exchange, in addition to the triggering events listed
39 in this paragraph, any other events listed in Section 155.420(d) of
40 Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section.

With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

1 (C) Claims experience.

2 (D) Receipt of health care.

3 (E) Medical history.

4 (F) Genetic information.

5 (G) Evidence of insurability, including conditions arising out
6 of acts of domestic violence.

7 (H) Disability.

8 (I) Any other health status-related factor as determined by any
9 federal regulations, rules, or guidance issued pursuant to Section
10 2705 of the federal Public Health Service Act.

11 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
12 insurer shall not require an individual applicant or his or her
13 dependent to fill out a health assessment or medical questionnaire
14 prior to enrollment under an individual health benefit plan. A health
15 insurer shall not acquire or request information that relates to a
16 health status-related factor from the applicant or his or her
17 dependent or any other source prior to enrollment of the individual.

18 (h) (1) A health insurer shall consider as a single risk pool for
19 rating purposes in the individual market the claims experience of
20 all insureds and enrollees in all nongrandfathered individual health
21 benefit plans offered by that insurer in this state, whether offered
22 as health care service plan contracts or individual health insurance
23 policies, including those insureds *and enrollees* who enroll in
24 individual coverage through the Exchange and insureds *and*
25 *enrollees* who enroll in individual coverage outside the Exchange.
26 Student health insurance coverage, as such coverage is defined at
27 *in* Section 147.145(a) of Title 45 of the Code of Federal
28 Regulations, shall not be included in a health insurer's single risk
29 pool for individual coverage.

30 (2) Each calendar year, a health insurer shall establish an index
31 rate for the individual market in the state based on the total
32 combined claims costs for providing essential health benefits, as
33 defined pursuant to Section 1302 of PPACA, within the single risk
34 pool required under paragraph (1). The index rate shall be adjusted
35 on a marketwide basis based on the total expected marketwide
36 payments and charges under the risk adjustment and reinsurance
37 programs established for the state pursuant to Sections 1343 and
38 1341 of PPACA *and Exchange user fees, as described in*
39 *subdivision (d) of Section 156.80 of Title 45 of the Code of Federal*
40 *Regulations*. The premium rate for all of the ~~health insurer's~~ health

benefit plans in the individual market *within the single risk pool required under paragraph (1)* shall use the applicable *marketwide adjusted* index rate, ~~as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA,~~ subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to ~~an individual health benefit plan that is a grandfathered health plan.~~

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after the date of that repeal or amendment and individual health care benefit plans shall thereafter be subject to Sections 10901.2, 10951, and 10953.

1 *SEC. 24. Section 22.5 of this bill incorporates amendments to*
2 *Section 10753.05 of the Insurance Code proposed by both this bill*
3 *and SB 1034. It shall only become operative if (1) both bills are*
4 *enacted and become effective on or before January 1, 2015, (2)*
5 *each bill amends Section 10753.05 of the Insurance Code, and (3)*
6 *this bill is enacted after SB 1034, in which case Section 22 of this*
7 *bill shall not become operative.*

8 ~~SEC. 27.~~

9 *SEC. 25.* No reimbursement is required by this act pursuant to
10 Section 6 of Article XIII B of the California Constitution because
11 the only costs that may be incurred by a local agency or school
12 district will be incurred because this act creates a new crime or
13 infraction, eliminates a crime or infraction, or changes the penalty
14 for a crime or infraction, within the meaning of Section 17556 of
15 the Government Code, or changes the definition of a crime within
16 the meaning of Section 6 of Article XIII B of the California
17 Constitution.